THE CANADIAN NURSE

VOLUME 52 • NUMBER 7
MONTREAL

Highlight for
JULY 1956

CONFUSING NOTIONS OF MENTAL HEALTH
A. B. Stokes, M.D.

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VIEWING HOUR

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THE CANADIAN NURSE
L'Infirmière Canadienne

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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00. U.S.A. & foreign: one year, $3.50; two years, $6.00.
In combination with the *American Journal of Nursing* or *Nursing Outlook:* one year, $7.00.
Single copies, 35 cents.
Make cheques and money orders payable to The Canadian Nurse Journal.
Detailed *Official Directory* appears in **June & December.**
Change of address: Four weeks' notice, and the *old* address as well as the new are necessary.
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Authorized as Second-Class Mail, Post Office Department, Ottawa.
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Between Ourselves

THROUGH THE YEARS many superlatively good addresses have been published in *The Canadian Nurse* that are practically timeless, so far as their appropriateness is concerned. This splendid material is only uncovered occasionally by postgraduate students doing thesis work. It is our plan to reproduce some of these articles from time to time so that a new generation of nurses may profit by reading them.

The first such reprint is the excellent article by **Sir Fred Clarke** that was published in our August, 1932 issue. At the time he delivered the address to the biennial convention at Saint John, N.B., Dr. Clarke was professor of education at McGill University, Montreal. Later, he returned to England as director of the Institute of Education, University of London. He was knighted before his death.

In reading this article, bear in mind that the survey of nursing in Canada, conducted by Dr. George Weir, was a newly accomplished guide to future developments. Dr. Clarke was very aware of it as he prepared his address.

* * *

As we edited the article on salt-losing nephritis for publication we made some enquiries locally regarding the incidence of this unusual condition. Our internist informant told us it is a very rare condition — he had not seen a patient with this disease during his practice. The fact that it occurs very seldom is reflected in the almost complete absence of reference to it in textbooks and certainly warranted its inclusion here.

* * *

As a participant in the specially arranged course at Canadian Civil Defence College, Arnprior, **Miss Jean MacGregor** was very much impressed by the realistic appearance of the wounds grease paint and plasticine produced in otherwise healthy-appearing individuals. The handbook to which she refers gives clear and concise instructions regarding the preparation of a wide variety of casualty simulations. It should prove a clever and useful adjunct for nursing instructors. But don't leave the book around casually for possible investigation by non-nursing colleagues or they may put on a demonstration of an aspect of casualty simulation — without benefit of grease paint!

* * *

In response to numerous requests for information, we have been assured by Mr. Robin Strachan, manager of the college-medical books department, of the Macmillan Company of Canada Limited that they are "very much in business." Books published by The Macmillan Company of New York may be procured from Hollinger House, 25 Hollinger Road, Toronto 16. The Macmillan Company of Canada can be reached at their usual address, 70 Bond St., Toronto 2. Be sure to look on the fly-leaf to find which division has published the particular book you want to order.

* * *

Those of you who were reading *The Canadian Nurse* in September 1949 will remember the excellent summary of clinical laboratory procedures that **Dr. E. M. Watson** had prepared for us. Or, perhaps you remember referring to them in reprint form during your undergraduate days for over 7,000 such reprints were sold.

We are delighted that Dr. Watson's completely revised material will be available in next month's issue. We anticipate that there may be a demand for reprints again though at the time of writing this we have no estimate of what the price might be. We are including a half-page order form in this issue so that instructors who wish them for their classes, and individual nurses, may be ready, as soon as the August issue is received, to send off their order for copies.

* * *

Last March, the School of Nursing of Dalhousie University sponsored an exceedingly interesting and well attended institute on the Nursing Aspects in Rehabilitation and Care of the Chronically Ill. The principal speaker was **Miss Elisabeth Phillips** of Rochester, N.Y., who delivered four pertinent papers and participated most actively in the ensuing discussion. All of these papers will be reproduced in consecutive issues. They would make an excellent basis for group discussions at chapter meetings next fall.

It's fine to believe in yourself. Just don't be too easily convinced.

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New Products

Edited by DEAN F. N. HUGHES

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I. D. M.

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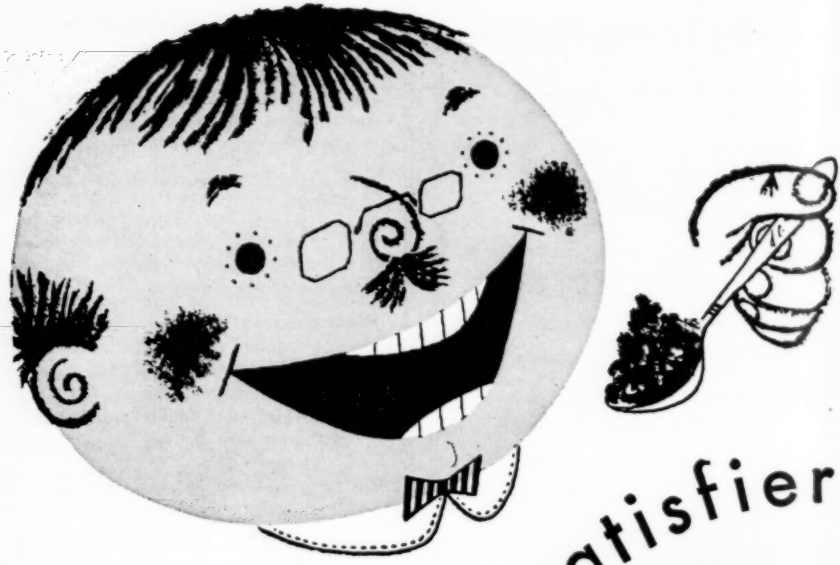

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L'Infirmière Canadienne

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 52 NUMBER 7

MONTREAL, JULY, 1956

In Time of Need

WE NURSES AS A GROUP are a very practical people. Our professional training helps to foster that characteristic — we spend very little time directing our thoughts toward the intangible. The large majority of us — working at the bedside, in the home or in the community — are concerned with very tangible situations and problems. As a result we sometimes tend to look a bit askance at any new idea directly affecting our work which seems to savor of the hypothetical and to accept it with reservations until the practical worth has been demonstrated to our satisfaction. Perhaps this has been the underlying reason for our attitude toward civil defence planning.

Mention "civil defence" and the usual reaction was, perhaps still is to some extent, to conjure up a picture of enemy planes and the H-bomb, coupled with the attitude that "It can't happen here," or "We'll all be killed anyway — so what's the use." Except for those who considered it more thoughtfully, we pictured a whole new body of agencies being painstakingly developed to meet a situation which might never materialize.

On the surface, the whole idea seemed neither practical nor workable. Patiently and quietly, those who are immediately concerned with the evolution of disaster planning have presented the practical evidence necessary to prove that such a program *is* worthwhile and has a definite bearing on our contribution as good nurses and good citizens.

What has changed our thinking?

To begin with, the term "civil defence," essentially warlike in tone, is giving way to the less restricted phrase "civil disaster" — misfortune affecting the citizens of a country in general. Thought of in those terms, civil disaster planning is something which we are much more willing to accept.

Recently in Canada we have had several disasters whose scars we still bear. Torontonians will not soon forget or easily erase the havoc produced by Hurricane Hazel.

The people of Winnipeg, with the memory of one flood fresh in their minds and the possibility of another such incident an ever-present reality with the coming of Spring, are actively concerned in offsetting the effects of such disaster through organization of their public services. These exam-

ples demonstrate just what civil defence or disaster planning really is — an extension of community services *already in existence,* and coordination of their efforts with the chief objective being to save life whether the disaster be fire, flood, tornado or the explosion of an atom bomb.

One of the largest groups of citizens to attend the course of instruction at the Canadian Civil Defence College, Arnprior, was drawn recently from the ranks of the nurse educators, directors of nursing, public health organizations and other key nursing agencies. They represented every province in Canada — provinces whose civil disaster planning ranged from much activity to very little.

Naturally, they were concerned with the effect of such planning on nursing education, on hospital routine, on community health agencies. Consideration of the possible effects brought some very interesting observations, questions and comments to the fore — all the more interesting because the problems presented were already so familiar to us.

The importance of the nurse as a leader was repeatedly stressed, which, in turn, stimulated consideration of how best to develop this quality in the young women who enrol in our schools of nursing.

It will probably mean a more critical analysis of present methods in this respect. The place of the auxiliary worker — be she nursing assistant, ward aide or volunteer worker — has required clear definition for some time. Civil disaster planning simply points up the need for such definition and the importance of adequate leadership if this group is to give maximum service in time of emergency.

The curricula of Canadian schools of nursing have been, or are being subjected to rigid evaluation in all provinces. The possible effect of a large-scale disaster on the program of a school of nursing and on the lives of its students indicated where further revisions could be made — revisions useful under peaceful conditions as well as in time of disaster.

It sparked more thought in regard to the relative effectiveness of 2-year versus 3-year programs of basic nursing education. To be even more practical, after watching a demonstration of the activation of an Advanced Treatment Center and the very effective use of casualty simulation, many a nursing arts instructor must have visualized the numerous possibilities for casualty simulation as a teaching aid. How much better to *show* the patient in shock than to *talk* about the condition.

The exceedingly well illustrated handbook, "Casualty Simulation," is available for the modest sum of $1.00. Copies may be procured from The Queen's Printer, Ottawa, Ontario. Indeed, planning at the Federal level in casualty simulation has reached a stage which makes its use at the local level a definite possibility in the near future.

The emphasis placed upon instruction in first aid techniques varies considerably from one school of nursing to another. Such knowledge, if adequate, could be an invaluable aid in time of calamity. Consideration is already being given to which year of training and how extensive first aid training in our curricula should be. Civil disaster planning may help us determine the answer. To further aid us a new edition of the St. John Ambulance Association First Aid book has now been released and includes the most up-to-date instruction in first aid under emergency conditions.

Civil disaster planning or civil defence, then, is not the bugbear we once feared but is simply the coordination and extension of existing services. The acceptance of responsibility is almost synonymous with nursing. Is not participation in civil disaster planning another responsibility for us to accept? Might we not consider it as an extension of *our* services?

J. E. MacG.

If your foot slips, you can always recover your balance; if your tongue slips, you can never recover your words.

Confusing Notions of Mental health

A Problem for Nurses

A. B. Stokes, M.D.

A high occasion of this sort is one of good health and good cheer. For a few short days we leave the day to day responsibilities behind us and in a chosen setting meet old friends, exchange news of one another, compare experiences, seek new ideas and in a hundred and one ways consolidate our membership in a great and worthy vocational group. A feeling of respite, of comfort, of confident strength, of personal expansion and growth supplants the worries of taxing effortable practice. There is a sharp contrast between the pleasure of this sort of occasion, which on the whole is without self-conscious concern, and the recurring necessity in our working days of making sometimes grave, worrying decisions on behalf of sick people. For the moment we are walled off against the "madding crowd" to look anew and dispassionately at problems which ordinarily may be confusing and vexatious. In the present instance the problem is that of mental health.

Whenever a term like *mental health* is used there is an immediate expectancy that it will be defined. To my mind definitions are sometimes as much a hindrance as a help: whatever definition is attempted of any subject there is always a penumbra or shading off from the central defined point. In some instances the band of shading is narrow, as say in the definition of a chair; in others it is wide and inclusive of many elements not captured at the point of focus. One such is physical health. Try and define physical health and you will be in difficulties. After many imperfect attempts you will suddenly say "I can't define physical health absolutely but I know what it is because all my professional experience is in the health field." You assert the recognition achieved by a continuing, intimate, personal experience as more useful than the definition. From my point of view mental health is in like case.

Mental health may be defined as "personal well-being in social living." The definition will not stand up to penetrative criticism nor will any other. To develop a theme of mental health around any definition would be limiting to our purpose. Instead we might look at the way in which, by reason of our experiences, it developed for us as a recognizable entity despite its complications and extensions. To do so we will take a prototype nurse or doctor and follow the stages of a maturing concept.

The "madding crowd" of Gray's Elegy, which I am assuming exists outside this pleasant concourse, is not a 'mad' crowd. It is *distracted* more or less by the urgent problems of personal and communal living. Physical and aspirational needs meet opposing forces and are overcome, or adjusted by mutual concessions, or emerge triumphant. Such interplays occur, recur, occur again over the long passage of marching time, so that in a very real sense life is effortful and can never be thought of in terms of unalloyed security, success, or pleasure. For most a lot of fun is gained from the hurly burly as well as a lot of hurt. Everyone slips occasionally but is soon back firm footedly. Some fall heavily and have to be helped. Of these it may be said they have broken down in living.

The breakdown in living is a matter of concern not only to the individual but also to the crowd. The urgency of effortful living and the occasional vulnerabilities of every one are circumstances which bring about the designation within the crowd of some members devoted to the well-

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being of those who are in jeopardy. They are still of the crowd but are given prerogatives and privileges linked to titles, such as pastor, lawyer, politician or social worker, and to areas of service spiritual, legal, political, social and the like. Among the earliest and most privileged, linked inextricably to the Shakespearian ideal "to study for the people's welfare," are nurses and physicians with health as their area of service.

It is hard for us here to recapture our first recognition of the nature of the emotional forces in the community, which stirred our early interest in becoming nurses and physicians. Certainly we saw the personal opportunity of entering a well respected profession, of using our talents in such a way as to receive approbation and acceptance in a measure which countered any suggestion of inimicable servitude. But more, we had a very real sense of transmuting illness into wellness and thus of contributing to the welfare of others. In those more idealistic days our humanity was as involved as our intellect in making the decisions for our future.

The decision once made we entered a period of training in a social institution called a hospital. This social institution had emerged in history as a place apart where sick people were housed and cared for. When we came into the hospital most of the ill people were in bed. Their living had been disrupted by reason of heart trouble, or a cancerous growth of the womb, or a recently fractured thigh. We addressed ourselves quickly to the task of knowing all about these conditions, how they were discovered, how they had come about, what was to be done for them, what our part would be in treating the condition. Very properly we started at the beginning, learning about the structure and function of organs, about pathological processes which destroyed structure and disturbed function. We became aware of a vast array of technical procedures designed for particular investigations and specific treatments. Always during this exciting time of intellectual stimulation, by both precept and example, we were coached to a sympathetic understanding of the patient's current needs — to make him comfortable, to encourage the relatives and friends, to make helpful suggestions of a common sense kind at a time of stress. Now it was that we had a full sense of gratification in our vocation, that we were using an increasing expertness authoritatively and well, that we were treating disease and the person with the disease to his betterment. Our first notion of a mental health principle was born.

With increasing experience in nursing or doctoring the patients in our hospital we found there was a great deal of difference in the attitude of our patients. Whereas many were resilient and emerged from the incapacities of their physical disease to bear our cajoleries and encouragements and to want to get home, others seemed less responsive. Not infrequently the unresponsive ones, while complaining of physical symptoms, had no organic disease. They had pains, or bowel looseness, or stomach upset, or muscular weakness but nothing that could be tackled in a very direct or specific way, as it seemed. They were in the way, as it were, sometimes demanding, sometimes captious, occasionally contentious. One might be sorry for them because of an obviously disturbed family relationship, perhaps a faithless, feckless spouse, or an unhappy work situation. But more often there seemed nothing excusing in the background, and the disability became almost accusingly designated as neurotic with the implication of someone not trying or not pulling themselves together. Had we been less involved, less identified with the work of curing organic disease, we would have appreciated the operation of group rejection and the worsening of the neurotic disability because of the rejection.

Of course more obvious rejections were very evident. The disturbed, deluded puerperal psychotic, the very depressed tuberculous patient threatening suicide, or the obstreperous alcoholic were quickly transferred elsewhere perhaps to a mental hospital or refractory ward. A perfectly proper course of action would almost certainly have been associated with some thinking that these particular patients were inevitably marred by tainted stock or poor qualities of character. Only later, by the chance of occasion, would we

sometimes meet these same people and to our somewhat embarrassed astonishment find them hale and hearty. We wondered how recovery had come about and in that surmise propounded our second mental health principle that **disturbed people sometimes recover.**

These general hospital experiences of the vagaries of human behavior become tremendously expanded when, with training completed, we entered into family or public health practice. Now the totality of illness rather than a selected group of organically ill persons became our concern. Certainly, chronic instances of organic disease or organic cases requiring rehabilitation were plentiful for our ministrations: but now we were thrown more on our own resources. Over and above these technical accomplishments suitable for community work we had to rely on ourselves as persons and use ourselves as instruments of medical purpose. To help the people we were supposed to help some important personal relationships had to be established and used.

So long as we could still do a dressing, or arrange a diet, or give an injection we were the more confident. But in the new, to us, community scene we found ourselves meeting disablement which more and more seemed unrelated to physical disease although frequently associated with physical symptoms. We might rush in with nostrums and placebos but inevitably a time would come to face the fact that this disability, as crippling as any, arose within the circumstances of life adjustment of the individual. Now, call them neurotic or psychotic as we may, they were problems of ill health perhaps reminding us of the World Health Organization's definition "that health is a state of complete physical, mental and social well being, not merely the absence of disease or infirmity."

At this stage of an interest maintained by the realities of the suffering and distress we were witnessing, we might have made a number of observations, some external to ourselves, some within ourselves. Outside the sphere of our own activity we noticed that people, with difficulties somewhat similar to our patient's, sought help through some human relationship important to them. They seemed to get a tremendous support and encouragement maybe from a priest, or a friend, or in the instance of a young person from a schoolmaster. Such supports seemed to be the more necessary the more family cohesion was lacking. Where the family grouping was accepting, not of necessity in an uncritical way but in a manner which maintained bonds of relationship despite all upset, then the individual complaintiveness seemed less. These supportive relationships, as we observed them in the scene around us, were not dependent on material wealth or the appurtenances of easy living but on the quality of human experiencing. Within ourselves, perhaps suddenly, we realized that our patients were really seeking this quality of human regard from us, the privileged nurse or doctor to whom their homes and selves were opened. In short we found that to help persons in their living we must start, despite appearances to the contrary, with an appreciation of their worth. Sympathy from above was not enough. Understanding, in the sense of knowing and feeling as if within, was of paramount importance in working with the patient to a healthy outcome.

A realization of this sort was not reached without some trauma to ourselves. The demands of empathizing, as this knowing and feeling as if within is called, include a continuous testing of ourselves in a large variety of human relationships. The testing imposes a double burden — to be feelingly involved and to appraise the involvement objectively so that it might be used in practical fashion — to restructure the pattern of our patient's living, to meet his varying occasions. A new kind of thinking started for us which harked back to that human interest in people which initiated our professional concern in healing.

But, as we were about our business in the community looking at and testing ways of helping ill people, whether their disablement was associated with organic disease or not, we became aware of other happenings. The crowd, while no doubt using expediently the strength of family groupings, the aids of the helping professions, and the supports of its focal organizations still

suffered its casualties impatiently. It tended to act impulsively either for the patient claiming short cut magical cures, or against the patient by reject attitudes and procedures. As to the former, each new hope, whether a miracle drug or an ingenious shock technique or some device of surgery or suggestion, was built up by the processes of communication into an established certain cure. As to the latter, each prick in the bubble of hope, was followed by a metaphorical washing of hands and a withdrawal of favor, sometimes even of interest. "Sink or swim" was the attitude with sinking equal to death and swimming the labored incompetence of a potentially worthy citizen contributing to the public weal. It was this combination of "blow hot, blow cold" "filling and backing" which we found disconcerting. The steady advancement of knowledge and control through knowledge of breakdown in living seemed for us the more remote.

However, because of our discipline in nursing or doctoring, although aware of these happenings we tried neither to endorse nor promulgate the impulsive hopes or rejections of the crowd. Having sampled for ourselves the effects of our personal relationships to our patients and seen some of the consequences of impulsive crowd action, we gave more attention to and placed greater credence on the kinds of social groupings which promote individual strengths. As opportunity served we may have encouraged our patient, in the light of our understanding of his needs, to take part in a group, perhaps a remedial group or one devoted to rehabilitation exercises, perhaps an old age group or a youth activity at a Y.M.C.A. Later we may have tried for an acceptance within a vocational group, an acceptance brought about, perhaps, despite a disability but with the recognition of assets for the job in hand. Insofar as our progressing experience warranted it, we came to the recognition that society was not really a haphazard crowd of people but was made up of fluctuant groupings each with some internal strength and some with an enormous capacity for incorporating and sustaining the most unlikely people. Occasionally we glimpsed within a grouping the operation of family-like relations, not only positive in terms of regard and affection but negative in terms of warring rivalries and rebellion against authority. Such occasional insights built up into a slow realization that our patients looked on us, and played their parts towards us and other people, in a manner determined by their particular family experiences. On looking at ourselves we might have seen with clearer understanding how our feelings and attitudes towards people and situations were brought into being by our earliest life relationships with parents, brothers and sisters. We would have wondered about the mode of incorporation of these events within ourselves so that 20 or 30 years later they still, in part, determine our actions.

At this stage we came up against the problems of life development, personality integration and the capturing of experience, both knowing and feeling, within the physical substance of the brain. If the brain is the seat of learning, not only intellectual but emotional, then its function may be shifted both by methods of relearning and methods of physical modification. The great ideational chasm, which had almost certainly disturbed us hitherto, between the so-called psychological and the so-called physical could now be bridged. The personal adaptive functioning of the brain was continuously related to present circumstances but the relationships included important elements from the past. To arrive at this position we had used a general vocational experience. By using common sense and insightful understanding we had been more helpful to our patients in getting them on their feet in a hurly burly world. To go further would mean a degree of specialization.

Specialization need not concern us unduly here excepting to comment on the balance and the detail of the notion of mental health we may have formed in our general practice of nursing or doctoring. If we have decided to get a more intimate knowledge of specific work wholly devoted to mental illness we enter a psychiatric institute or a mental hospital. Here we find very many patients including those whom we previously noted as being sent on from the general hospital. It would

strike us immediately that most are up and about and the relatively few are confined to bed by reason of organic disease. Some of the patients, up and about, have long standing brain pathology subsequent to infections, or trauma, or tumors, or degenerative processes. Nonetheless, and contrary to a general hospital, the etiological emphasis is not on physical disease. Particularly in the mental hospital we would learn that many have been resident for years. Yet if we looked carefully through their records we would have difficulty in finding a substantial number with hereditary predisposition to mental disease. The notion of an inevitably malignant gene producing mental disturbance is as untenable as, say, with diabetes mellitus.

Another point would strike us, reviving the memory of our astonishment at seeing in those earlier days the occasional recovery — very many patients recover and are discharged to home and family as competent worthy people. We would see that each of the treatment methods, which in our community practice had been bruited abroad as the one and only cure, had representation in the hospital's work. Each would be employed circumspectly with proper selection of cases. One here would be on a modern tranquilizing drug, there a form of electric convulsive therapy, this one would be receiving insulin shock therapy and that one has had a lobotomy. We would recognize that none is as yet specific but that patient researches are continuously being undertaken to find out why these treatments act when they do act and in what circumstances they act best. It would be our part to help in such research enquiries.

Although these physical treatments were often dramatic in their effect we would see that in other instances the treatment of choice was psychotherapy. We would find that there was nothing mystical about such treatment. Despite many variations of technique the essential elements were the establishment of a personal relationship with a physician, which was used to explore past feelings and attitudes in order that unlearning might be followed by new learning. Indeed, we would find ourselves continuously involved in processes of relationship which embraced the same psychotherapeutic principles.

One particular surprise would await us. With our patients up and about we would find it necessary to organize our ward as a social group, that the interplays of personality might be moulded as far as possible into a mutually supportive whole. The interplays will be of particular importance in the period of rehabilitation and weaning from hospital to a well founded family and vocational adjustment.

These specialist studies will reveal great gaps in knowledge and progress by trial and error methods. The state of practice will be very reminiscent of the early days of medicine and surgery: firm preventive measures will still seem elusive, although glimmerings of opportunity will be marking the right directions.

With such a general and special experience behind us, nurse and doctor will have a recognition of mental health. Genetic, physical, psychological and social elements combine systematically and without schism into a personal whole, which meets the affronts and favors of living steadfastly and with resilience. To repair a breakdown in living, physical, psychological and social methods are to hand. To use them common sense and disciplined enthusiasm are not enough but when allied to a sensitivity in human relations small shifts of adjustment will accomplish great good in terms of "personal well being in social living."

Removal of tonsils and adenoids should be undertaken only after a careful study by a physician familiar with the child's medical history. Tonsillectomy and adenoidectomy are very valuable procedures when needed but they are not the cure-alls some people believe. A study carried on in a private school over a 20-year period showed that removal of adenoids and tonsils made no difference in reducing the number of colds in children in the first three grades.

— *Scope Weekly*

Impact of Chronic Illness

ELISABETH C. PHILLIPS, B.S., M.A.

IN ORDER THAT WE MAY ALL start out thinking in the same terms, I would like to give you a definition of chronic illness. This is one that has been prepared by the National Commission on Chronic Illness in the United States and it is, I believe, as clear and specific as any that I have ever come across.

> Chronic disease or impairment comprises all impairments or deviations from normal which have one or more of the following characteristics: Are permanent; leave residual disabilities; are caused by non-reversible, pathological alterations; require special training of the patient for rehabilitation; may be expected to require a long period of supervision, observation or care.
>
> The term "long-term patients" includes only those persons suffering from chronic disease or impairment who require a prolonged period of care, that is, who are likely to need care for a continuous period of more than three months in an institution or at home, such care to include medical supervision and/or assistance in achieving a higher level of care and independence.

In the United States chronic illness is responsible for 70 per cent of all invalidism and partial disability and one-sixth of our total population are its victims. In Canada it has been estimated that there are one million permanently disabled with nearly half of these totally disabled, and that the disabled make up 3 per cent of the total population between age 18 to 64 years.

Chronic illness occurs half again as frequently among the lowest income groups as among those in even slightly higher brackets.

Chronic illness is perhaps the most important, urgent and complex problem that society faces today in its attempt to care for its members and itself.

We all know that both the numbers and percentages of persons who are over 45 years of age are increasing rapidly. But what many people do not yet realize is the companion fact that of those persons who are well at the age of 45, 10 per cent will acquire, during the next five years, a chronic illness or major impairment which will require at least periodic, if not constant medical care for the remainder of their lives. Nearly 25 per cent of those who are well at age 60 will develop a chronic illness before they are 65. Forty per cent of those who are well at 70, and 57 per cent of those who are well at 80, will become chronically ill within the next five years. In other words, as our population increases in its average age, so will chronic illness increase. Sixty per cent of all disabled people in Canada are over 45 years of age.

Of course, chronic illness is not limited to persons over 65, nor on the other hand, is aging synonymous with chronic illness. We must never forget that fact, but all the same, an aged population is also the one most vulnerable to the inroads of long-term illness.

Even with an accepted definition in mind, the words "chronic illness" have a very different meaning to different people. To one they suggest something that is hopeless; to another something that is going to last a long time; to another, something that must be endured; to another something that comes to most of us with age; and to yet another, something disagreeable that must be shut out. To some nurses chronic illness means frustration, boredom or even disgust; to others, it is an almost unexplored area of service which offers excitement and challenge.

There is *one thing* that chronic ill-

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This is the first in a series of four papers by Miss Phillips that were presented at an institute on Nursing Aspects in Rehabilitation and Care of the Chronically Ill, held under the auspices of the School of Nursing, Dalhousie University, Halifax.

ness means to all of us — to those in the health and social welfare professions, to local, national and international communities, to individual families and patients, to society as a whole. Chronic illness is a problem that to date is only partially solved.

Of course, there are all degrees of chronic illness. In its broadest sense, almost everyone of us could qualify for membership in that not-too-exclusive club of the chronically ill. Our eye sight is impaired, so we wear glasses; our teeth have petered out and we have a pivot tooth or a bridge or even more! Our blood pressure is elevated, so we try not to lose our tempers; some of us wear arch supports; others take a vitamin pill each day; we complain of our sinuses, our ulcers, our joints, our stiff muscles. There are probably some of us who have a specific disease such as diabetes, arthritis or undulant fever. Yes, most of us know, and will admit, that we have some sort of a chronic physical disability even if we won't go so far as to admit to mental or emotional illness. Our attention in this series of papers will not be directed to the needs of people such as we who, outwardly, seem to be well or nearly so, and who are able to carry their share of work and play. We will be thinking, rather, of those who are disabled by some illness or impairment and how their lives can be enriched.

In the United States for the past five years, we have had a National Commission on Chronic Illness. This has been supported by a large number of national organizations including nursing. This is the commission whose definition I quoted above. In terms of this definition in the United States there are over five million chronically disabled persons. In Canada the number is nearly one million, exclusive of those with disabling mental illness. It has been estimated that for every chronically ill patient who is institutionalized there are at least three others who have never had adequate medical care, but who need it.

We must realize that a vast number of the chronically ill who are under medical care in institutions or at home are receiving what amounts to custodial care only. Custodial care may or may not be excellent so far as it goes, but it falls far short of even the most modest goals set for rehabilitation programs. It is not strange, therefore, that we are staggered by the enormity of the job ahead of us.

It has been carefully estimated that probably some seventy per cent of the chronically ill can be cared for at home satisfactorily if the communities in which they live have the following facilities in sufficient numbers:

1. Physicians, both private and clinic, who will make home visits.
2. Visiting nurses, practical nurses on the staff of visiting nurse associations or generalized public health nurses who are permitted to carry bedside programs.
3. Supervised homemakers.
4. Social workers who are able to make home visits.
5. Restorative services which will include occupational therapy, physical therapy, rehabilitation, vocational guidance and recreation.

Services for feeding many chronically ill and aged patients are now being seriously considered as a necessary community facility if these people are to remain in their own homes. In England, "Meals-on-Wheels" were established shortly after the war by many large cities. Such services provide hot meals two or three times a week to patients at home who cannot, themselves, shop and cook and who have no one to do it for them on a daily basis. The projects are all subsidized, but each recipient does pay something, usually six pence to a shilling for each meal.

"Luncheon Clubs" have been formed for the aged and infirm that provide social and sometimes educational activities as well as the meal itself.

Of key importance in the entire program for the care of the chronically ill are rehabilitation services. Vocational rehabilitation is, of course, important, but ability to return to competitive employment should not be the *sole* criterion of success in rehabilitation. A large proportion of the chronically ill will, if given the right type and quantity of help from physical therapists, occupational therapists and nurses skilled in rehabilitative measures, be able to take a more active part in normal living. Almost all of them will be able to either participate in or take entire care of their personal

hygienic needs, be able to feed themselves and become quite self-directing in diversional activities. The chronically ill may be divided into several categories:

1. The group that has had some impairment since birth. These people do not know what it would be like to be without it, but we must help them to live the fullest lives possible.

2. The group who acquired their impairment in childhood. These have probably adapted to their handicap but sometimes far from adequately and so they need help. The handicapped child's reactions are different from those of the person crippled in adult life who must make a major adjustment to a life unlike the former one. The child is frequently not greatly disturbed by a sense of difference, but may suffer from the difficulty of developing in an essentially unreal world which lacks the normal elements of education and play with contemporaries and the stimulus of physical adventure.

3. Those who acquired their handicap in adulthood, at a time when they are near their peak of productiveness. These people respond to the handicap in either of two ways — they are floored by it, or else they adjust to it well or poorly, depending on the adequateness of the help they receive.

4. Those who acquired their impairment after middle age. Many times, the impairment has had a very slow onset, in contrast to those occurring in the other age groups. Acceptance is usually marked by resignation or half-veiled rebellion.

In order to insure the efficient operation of any medical program for the care of the chronically ill — and this includes nursing as well as the other medical services — it is necessary that all persons attempting to carry out such a program have an understanding of the patient's reactions, fears and difficulties during the time when she is applying for medical help, undergoing treatment, and convalescing. The common deterrent to seeking medical aid are:

1. Ignorance of availability of such services and how to go about securing them.

2. Fear of the physical examination itself, and of the treatment that will follow.

3. Fear of the implications of helplessness and dependence once the patient "gives in" and asks for the help.

4. Concern for the cost of the care, and pride that makes him say, "If I can't pay for it, I can't have it." This is particularly true in the older age groups.

5. There is another deterrent to seeking help — the patient has become dependent upon his illness and gets satisfaction from it — strange as this may seem to others.

The reluctance to accept the help offered stems from much the same causes. As we become more aware of the implications of psychosomatic medicine, the reasons for many types of behavior in chronically ill patients become more clear to us. Anxiety and depression, for instance, are typical manifestations of the cardiac patient and of his family. This anxiety is often out of all proportion to the need for it as measured in terms of the disease itself. Everything must, therefore, be done to allay it. Unless it is allayed, recovery from the disease itself will be postponed. In extreme cases we now recognize the condition known as "cardiac neurosis" and realize that the only lasting treatment for this is psychotherapy.

A few years ago a test of eight basic emotional needs was administered to a group of 87 crippled children and 193 non-crippled children. No significant differences were found between the two groups in the presence and fulfillment of their needs which were found to be:

Belonging; achievement; economic security; freedom from fear; love and affection; freedom from guilt; decision making; understanding the world.

For both groups, the need to be free from fear was the strongest while the need for love and affection appeared to be over-met for the handicapped by over-protective parents, teachers and nurses. Both groups showed a need to be free from feelings of guilt, but the need appeared to be stronger among the non-crippled. Although in all emotional areas the children seemed strikingly similar, wide differences appeared among the individual children. Among the crippled children, the individual deviations indicated maladjustment based on mis-

understanding of the implications and limitations of the physical handicap.

Another study to determine the social relationships among a group of physically handicapped children, between the ages of 10 and 14, indicated that the child's intelligence and degree of independence of assistance (in inverse ratio to the disability) are significant factors in the acceptance of the handicapped child by other children. The obviousness of the handicapping defect and scores on personality tests had no significant correlation with the children's acceptability to the group.

Let us think now of what lasting illness of various kinds does to the individuals involved. In our culture the chronically ill person is often (though not always) judged to be inferior, that of a lower status than ourselves. He is looked down upon and is pitied. We should do everything in our power to place emphasis on qualities and characteristics that handicapped persons have in common with normal individuals. We must remember that the physical impairment which an individual has is only one part of the whole difficulty. The social and psychological elements are equally important. Dr. William C. Menninger of the Menninger Psychiatric Clinic in Topeka, Kansas, has pointed out that the adjustment of the crippled child or adult is affected by the attitudes of others towards his handicap. These attitudes are frequently irrational and hostile, running the gamut from curiosity, through pity and oversolicitousness, to fear, repugnance and complete rejection.

A major effort must be made to help people understand their prejudices towards the handicapped, or the chronically ill, in order to improve the well-being and opportunities of the patient. An attitude of sympathetic understanding on the part of families and all workers dealing with the handicapped person helps him to accept the reality of his physical impairment and difference from other people, and to find the compensatory psychological satisfactions provided by special educational and recreational opportunities and varied social relationships.

In our work with chronically ill patients, our own attitudes frequently obstruct us and prevent us from giving the kind of care that we should. We encounter our own mixed feelings about persons who are different from us and in many of us there probably are vestiges of our early childhood anxiety about differences. In any group of children, we can note anxiety regarding the child who is a stranger to them until they have felt him out and have been assured of his likeness to them. Perhaps we have an unconscious fear that this thing that has happened to the patient may also happen to us. One of our abstacles that we must overcome is our desire, as nurses, to over-protect patients. This very over-protection serves to set the disabled person apart from us and to emphasis his chronic handicapping. Perhaps this is what makes us tend to view these individuals in terms of their disabilities alone and to plan for their disabilities rather than to help them plan for themselves. We will help the handicapped individual only as we understand his needs as a person, not only the needs created by his handicap, but also those that he has in common with other human beings. Let us, then, examine some of these emotional drives which the chronically ill, as well as we who are well, have in common:

An urge towards aggressive dominance.

A longing for submissive security.

A need for satisfaction of physiological demands.

A desire to love and to be loved.

A drive to obtain an opportunity for self-realization.

A wish to shift responsibility for a frustration on to the shoulders of another.

You and I have these same characteristics, so does the physician, the banker and the common laborer. The well-adjusted person has learned to keep these things in balance, but this adjustment is easily upset by transitory fatigue, as well as lasting illness.

Emotional problems are closely related to disease in the elderly, as disease represents a greater threat in age than in youth. Old age has characteristic organic mental diseases and functional personality disorders which may yield to proper therapy.

It may be helpful for us, who give care to the chronically ill, to try to

evaluate the relative pressures of these emotional factors in each individual case and to realize the effect that just being chronically ill may have, because of these drives. A case story will help us to understand.

Mr. Ansco, 43 years old, was a very successful travelling salesman for 22 years. His job necessitated long hours and much travelling. It continually called for great mental activity and made great demands upon his originality. He led a full and extremely active life and he saved little of his income. Suddenly he was given a diagnosis of diabetes. A new type of life was described to him by his physician. He must slow down, he must eat regularly and carefully and only those foods on his diet list. He could no longer travel daily. He must give careful attention to his hygiene — not cut himself while shaving, be particularly careful of his feet, and so on. Then he must learn to give himself insulin, what to do should he get too much or too little of it and, above all, he must see his physician periodically.

This patient in the first rush of fear, sought and secured a job of selling "over the counter," but soon discovered that he hated it. It no longer gave him an opportunity for self-determination and expression as his travelling job had. Night after night he went to his room, closed the door and read until the wee small hours. He was disagreeable, his temper was short, both on the job and at home. He disregarded his diet and blamed his wife for "not preparing meals that were fit to eat." He forgot to take his insulin, or broke the syringe or failed to renew the prescription. He broke his appointment with his physician. He had fits of depression that became increasingly frequent. In an effort to overcome them, he went on all night parties with his friends or on "food binges" when alone, flaunting the regime laid down by his physician.

Yet, Mr. Ansco was a man far above the average in intelligence. He understood the rationale of his diet, why he must be careful and conserve his strength. What then made him behave in the way he did? Could it be that his desire for aggressive dominance had become exaggerated, that he resented his illness and that "being a diabetic" lowered him in his own eyes and, he believed, in the eyes of others? Could it be that he had lost his sense of security in life? Could it be that he was worried that he would no longer be able to support his family? Had the psychological impact of learning that he had a chronic disease been traumatic? Was he attempting to shift the responsibility for this illness to his wife's shoulders? Could it be that through all of this behavior he was attempting to deny the very existence of the disease?

It is quite possible that affirmative answers to any or all of these queries might well be made. It is equally possible that had more thought been given to the way in which the disease was described to him and the way in which his wife received the news and adjusted to his illness — had all of these things been done somewhat differently — the impact of this particular chronic illness could have been lessened and a much happier adjustment to the disease could have been made.

Human behavior is a fascinating subject. We who dare to give care to the chronically ill must learn as much as we possibly can about the many *possible* behaviors our patients may exhibit. This will do three things — all equally important. It will help us create empathy with the patient and by so doing accept the behavior resulting from the disease itself. It will put us in a position where we can give him real help, which is even more important. It will do much to prevent our own frustration and discouragement while caring for long-term patients. In other words, it helps us to be *therapeutic* nurses, happy in our patient relationships, because we understand something of the motivation of their behavior as well as our own.

All of this works equally well with the opposite type of patient — the one who revels in his illness and follows every medical suggestion to the *nth* degree. This is the patient who resists strongly all efforts to help him to help himself, who wants to remain ill and dependent, although he may deny this most emphatically.

Almost all adults and older children go through a period of mourning when they are told that they have a chronic illness. This is natural as they begin to realize that life will be affected circumstantially and psychologically in

varied ways and in varying degrees. Insofar as these conditions bring change, the factors determining the nature and the degree of the individual's response are his age, sex, prior life experience, prior personal development and the timing of the onset of disability in relation to other events of his life.

This factor of timing is sometimes decisive. For example, a man immersed in humiliation and defeat at being unemployed, may sustain an injury or fall ill. At such a time the disability may be seized upon and used to the utmost as a more acceptable basis for being unemployed than not being wanted in the labor market. The same mishap in time of employment might not have brought the same gratifications and therefore, not being useful, would not be clung to in the same way.

Or in old age, when the future is uncertain and life in general has become frustrating, illness or a handicap may be used as the means to return to early infantile gratifications. The person may derive attention and a feeling of safety and comfort through the care which his disability conscripts. This is not necessarily the case, however, for if the person has well entrenched patterns of self-dependence, he may resist his disability or deny its existence through refusing medical care and attempting to carry on as of old.

An important factor determining his choice of a solution may be the response of family members to his disability. Their anxious over-protection may drive him to further lengths in denying his limitations, for it may encourage regression. Their indifference and neglect may provoke regression in order to command attention or it may block him in getting help which he genuinely needs.

Likewise in adolescence when the young person has not a secure place in the adult world and when he has considerable anxiety about his status among his peers, a physical handicap or chronic illness, which limits his activity may be deeply disturbing. He may solve the problem by regression to childhood or he, too, may resist the limiting reality of his handicap through over-reaching himself in activity and through refusing to use proper measures to safeguard his welfare. Again, decisive factors in determining the nature of his response are his prior personality development and the response of others, notably his family and his friends, to his disability. Above all he may need help in planning realistically for the future.*

The care of the chronically ill is one of the most important problems facing society today. It is, of course, an interdisciplinary problem, but this does not mean that the nursing profession should not take a leadership role in solving many aspects of it. Nurses must, of course, work within a societal and organizational framework, but we do need to define and work on the nursing problems in these areas. This means that we need first to experiment in ways of providing a greater quantity and quality of nursing for these patients; second, we need to see how we can prepare nurses in in-service educational programs as well as in basic and advanced studies to render this type of nursing, both directly and through the supervision and direction of auxiliary personnel. It is not possible for us to shift our responsibilities for these things to other shoulders.

While we are working on these particular aspects of care to the chronically ill, we need to seek and then make use of opportunities for us as nurses to work with members of the other disciplines to solve those other aspects of the problem which can be solved only through an inter-disciplinary approach.

* Common Human Needs by Charlotte Towle, published by the American Association of Social Workers, 1 Park Avenue, New York 16.

When counting your birthdays, don't peer ruefully into the mirror to add up your new wrinkles, if any. Rather rejoice in the fact that you have another full year of new friends, new experiences, new blessings to add to your wonderful collection of lifetime memories; to make you a wiser and better person for the year to come.

— Esther Baldwin York

NURSING EDUCATION

Life, Profession and School

SIR FRED CLARKE

AN OLD FRIEND OF MINE once wrote a very able book to which he gave a title wherein the word "Evolution" was used. When it was suggested to him that the book itself had very little to say about any "Evolution" his reply was: "Yes, I know, but the publishers had the title they wanted, and I had a title under which I could say what I wanted."

So much for titles. I am afraid I must offer the same kind of excuse for the title I have chosen for this paper. It is just a wide-open umbrella under which I can find room for what I wish to say.

Stated in general terms the task I am attempting is one of a perspective sketch. I wish to look at our problem of the education of nurses from the outside, as it were, so as to view it in its setting of current thought and practice, both in education and in the wider field of social and cultural tendency.

A venturesome undertaking, to be sure. For the world of thought and action and cultural movement, amid which our problem is to be seen, seems to grow increasingly chaotic. It is a world where, to use an Irishism, only the strong heads can keep their feet. Fortunately, our topic itself helps us. I know very little even yet about the problems of nursing education, and most of what I do know has been learned in Canada. But, coming fresh to some study of the question, I have formed at least one overwhelmingly strong impression. It is this: that no question of modern education can be more *typical,* more *representative,* of all the major issues than that of the education of nurses. Those who wish to clarify their thinking among the tangled threads of education today could find no better specific for their purpose than a study such as we are pursuing here. For it raises, and raises inevitably, all the major issues. That in itself is quite sufficient justification for the very comprehensive report which the Survey has arrived at under the far-seeing guidance of Professor Weir. In Socratic fashion he has followed the argument wherever it leads, and he has found, as all honest students must find, that it leads not only into every department of our educational thought and practice, but into the very roots of our common culture and into the fundamentals of our social structure. Truly, we are engaged on no small undertaking.

Let me illustrate the point by mentioning a few of the issues that arise. To begin with, we are concerned, in the function of nursing, with an indispensable social necessity. Done well or done badly, the job must be *done,* and the loss is immediate if it is not well done. Here at once we have both an urgent question of vocational education and a great issue in social policy, if the necessary supply of skill is to be both forthcoming and readily available.

Then the service itself becomes increasingly technical, demanding an ever-growing degree of specialized training. Here is an issue that is disturbing us all, in almost every field of education today, and it is no exaggeration to say that the fate of society depends, in large measure, upon the wise solution of it. How are we to provide for the carrying of this ever-growing load of technical *expertise* and yet save and strengthen the human souls of men and women? A society

consisting wholly or largely of "mere" experts: of people who are just experts and nothing more — what a horror to contemplate! Yet there seems to be some danger of it and the issue is nowhere more acute than in this field of the education of nurses.

Next, we may glance at the professionalizing process which gathers such strength in so many callings, in addition to that of nursing. There can be no doubt that change in the ambitions and status of women has given a powerful impetus to the process, which again, is full of danger. What is the recognized standard of competence to be? How is it to be achieved and maintained? What rights is the organized profession to exercise? How can the dangers of privilege be offset so as to safeguard the community without injury to the profession? Here are momentous questions both of education and of social control, and parallels to them can be found on every hand.

Finally, I will take note of another unsolved conundrum that is illustrated by our topic. It is of a more purely educational character and so can be used to lead straight into the main discussion. It is a question at least as old as Plato, and his discussion of it in the "Republic" is still relevant to our own case. It is this: What is to be the relation of so-called general (or liberal) to so-called special (or vocational) education?

How will that relation, when determined, be expressed, both in the educational progression of the individual and in the varied provision of educational means that the community must offer? In particular — in the case of nursing education, for instance, — what kind and degree of "general" education shall be demanded as a qualification for entrance upon specialized training. And again — perhaps even more momentous — what guarantees of continued cultural development of a broad human mind can be associated with or derived from the specialized training itself?

I call this last question particularly momentous. Why? For many reasons, the nature of which I can illustrate briefly. Are we quite sure that a preliminary course of so-called "liberal" training, given in the usual way, and carried as far as you like, is in itself a sure guarantee against the narrowing and dehumanizing influence of closely professional studies? Can we be quite sure that the "liberal" training has taken firm hold and that there will be no back-sliding? For an answer, look around on the world of successful professional people.

Again, is there any profession which requires more than nursing, that its professional training shall itself be penetrated through and through with a rich and liberal human significance, so that the clinical thermometer and the compress become, in themselves, symbols of salvation of more than a physical kind? Can we afford to make the same cardinal mistakes in the training of nurses that we made in the past in the training of teachers, where we gave the narrowest and most illiberal of trainings for what should be the broadest and most liberal of professions?

It is this need for a liberal handling of the technical training itself that constitutes a strong argument for associating at least the higher training of nurses with the university, provided always that the salt of the university retains its savor. I shall return to this point later. Here I wish to express a growing doubt about the validity of the distinction between "General" and "Special" education as it is currently drawn. The doubt, I think goes to the root of the matter. On the one hand I see men and women who have succeeded in drawing the means of fullness of life out of the seeming technicalities of vocational training. Such people find water-springs in a dry ground. Or, like Saul in Israel, they set out on the humble task of seeking the strayed donkeys and find a kingdom. For one, the building of motor cars, for another the management of a schooner, for another the cultivation of a farm, yes, even the management of a household may become the gateway of emancipation into a satisfying life.

On the other hand, I see men and women of alleged "liberal" learning whose only capacity seems to be to go on accumulating more and more of the same sort: walking museums, whose contents rattle more and more drily and harshly as life goes on.

Which of these has had the "liberal" training? Please do not misunderstand me. My point is not to decry so-called "General" education: anything but that! It is rather to emphasize the view that a course of education is to be judged by its product rather than by the content of its program. That is liberal which produces the liberal and special which produces the special. And the difference is quite as much a matter of spirit and atmosphere as of formal content on paper.

I think we have here *the* crucial educational issue for a modern democratic community where each must discharge his proper skilful task and all must share in, and contribute to the common cultural life. We have not really faced the issue yet, largely because we have been obsessed by a formal distinction between the liberal and the vocational, which is largely traditional, and exists today very much on paper.

Let me illustrate by a direct question: What percentage of the young people of our universities — yes — even in our high schools — are there, in the last resort, for any other than a vocational motive? Insistently, in season and out of season, we have linked formal education with *success*. That has been our real faith, our real working philosophy. Some of us have gone so far as to work out laboriously and in true modern fashion the comparative cash value of various levels of education; public school in hundreds, high school in thousands, and university in tens of thousands of dollars. And our young people have responded. Why should they not, to a faith which their elders hold so fervently? No wonder that, in their secret hearts, many of them look upon our fine "inspirational talks" about the value of education in itself as just so much insincere bunk.

The Nemesis for all this may be already at the door. I shall be immensely relieved if the next few years do not bring a violent popular reaction against the whole of our elaborate provision for formal education in school and university as a huge fraud. Unfair, no doubt, but it will be one more charge of the younger generation against the older that the latter has held out promises which it cannot fulfil. The donkey has made the painful journey and there are no carrots at the end of it. It is a little late in the day now to turn and rebuke the donkey for worldliness and to assure him that he has his reward in a much more spiritual and lasting sustenance than carrots.

Clearly it is the philosophy that is wrong, particularly wrong in the insincere guise of idealism behind which it hides the true grossness of its inspiration. In truth, where our effort should have been to liberalize the vocational we have succeeded only in vocationalizing the liberal, and have fouled the feeding trough of culture in the process.

The fundamental revision of values that is called for will have to extend far beyond the field of education in the formal sense. Here it is enough to repeat that, largely because of this failure, modern democracy has hardly begun to solve its real problem; since neither in the individual life nor in the life and culture of society as a whole has it succeeded in integrating the Useful and the Satisfying; the Necessary and the Fine; the Vocational and the Human; the Specialist and the Man.

Spurious solutions are around us in plenty. Among them one might mention Efficiency, the ideal of triumphant techniques: "Service offered usually only in return for a dividend, and combining, often unpleasantly, the lubricating grease of business with the treacle of sentimentality — even at its best its weakness is apparent in its vagueness; then the ideal of the "Good Mixer," in which I feel at times the philosophy of Professor Dewey seems to culminate; or again, the ideal of Conventional Conformity of the "Hundred-percenter," which one might gather, is satisfying to so many.

The real inadequacy of them all is evident in the vast reservoir of dissatisfaction that they leave behind, like a lake at the foot of a glacier. The lake is now growing turbid and agitated and threatens to give rise to a torrent. Its presence and the menace of it is the measure of our problem; a problem of education through and through since the threat comes not from an outside source at all, but from the bewildered minds and consciences of men and

women who feel themselves betrayed by the old gods, yet need strength and guidance in the painful task of finding more satisfying objects of devotion.

Note again, then, how typical and representative our problem of nursing education is, set in the midst of a society where men are in danger of losing their souls in a vain effort to gain the world. Nursing, with the intense humanity of its mission, the wide diversity of its contacts with the life of men, and the combined concentration and sympathy that it calls for in those who practice it: is any profession more concerned with the supreme task of keeping body and soul together in much more than a merely physical sense?

So the claims of nursing education offer a most favorable ground for testing out the validity of our principles. To that task we will now proceed — the consideration of the education of nurses as a model for the whole problem of an integrated education that will keep body and soul together, unify life and vocation, and build a well-proportioned scheme of values so as to guarantee richness of life without prejudicing wholeness and effectiveness.

(To be continued in August)

A Future Nurses' Club

TO HOLD ITS PLACE IN THE COMPETITION to attract promising high school graduates into its ranks, the nursing profession is continually casting about for new and attractive means of presenting information about itself. In the United States, Future Nurses' Clubs have already attained a comparatively firm footing and the trend is beginning to be accepted in Canada. The number of Canadian clubs organized up to the present is very limited — the one associated with the Sherbrooke Hospital School of Nursing, Sherbrooke, Quebec is a very recent addition and possibly the only branch in Eastern Canada.

The objectives of a Future Nurses' Club are few and very simple: (a) To acquaint students with the nursing profession. (b) To give students an understanding of the necessary requirements for entrance into the nursing profession. (c) To afford an opportunity for prospective student nurses to meet each other. Those who join are in no way obligated either to choose nursing as a vocation or to enter a particular school, should a career in nursing appeal. Membership is usually open to those in the senior grades of basic education but, in the case of the Sherbrooke club, has also been extended to high school graduates who are still too young to enroll as student nurses.

Programs at the meetings are designed to give members the opportunity to find out about nursing in general. Informal chats with student or graduate nurses; observation of student nurses in action either in the demonstration room or on the ward; visits to the various hospital departments — all these provide the prospective candidate with first-hand information about nursing and the life of a nurse, on and off duty. These meetings provide the means to give, in greater and more satisfying detail, the information necessary to interest educated, capable young women in nursing. Hospital visiting days for high school students or visits to schools by nurses as part of a Career Day program have provided, and still do, valuable but fleeting contacts lacking the personal touch which can be accomplished through an organization such as a Future Nurses' Club.

Sponsorship of such a club may be undertaken by a hospital but could quite conceivably be a project for an alumnae association, a provincial chapter or even a Home and School group. The Sherbrooke Club is the brain-child of the hospital's capable and energetic director of nursing education, Miss G. Norris. Along with her assistant, Miss M. Beckwith, she acts as adviser to an executive comprised of representatives from the various high schools in the immediate and surrounding areas. Sponsors of the club are Miss C. R. Aitkenhead, director of nursing; Mrs. W. H. Jones, recruitment committee convener; J. Whitman, president of the Student Council; Dr. A. N. Langford, professor of biology, Bishop's University; Dr. W. J. Klinck, chairman of the nursing committee; Dr. S. Marcus, attending physician.

One interesting feature of the executive of this club has been the appointment of a registrar-historian. It will be her task to maintain contact with members and record their eventual choice of career following graduation from school.

NURSING SERVICE

Epidermoid Carcinoma

LILY WATANABE

WITH THE EXCEPTION of tuberculosis and heart disease, probably no other condition has been so widely publicized as cancer. The public has been made aware of the extreme importance of its early recognition if present methods of treatment are to be effective. While the medical profession cannot, as yet, promise a sure "cure," the very good results obtained through early and thorough excision of malignant tissue and judicious use of x-ray therapy are indicative of their value. The etiology of any form of carcinoma is also unknown although advances in research seem to be bringing us ever closer to the day when this mystery, too, will be solved. No age group is immune but we have come to associate certain forms of cancer with particular age ranges. One of these forms of malignancy is illustrated in the story of Rosemary.

Rosemary was a 28-year old woman of Lithuanian descent. She was employed as a waitress in a downtown cafe in a large city and seemed to enjoy her work. Although happily married, she and her husband lived apart — seeing each other about twice a year — since financial circumstances made it impossible for Rosemary to maintain a home near the air base where her husband was stationed. Fortunately, she possessed an emotionally stable and well-balanced personality since her home environment tended to be unpleasant. Rosemary lived with her mother who seemed to lack both intelligence and understanding of her daughter's condition when she eventually became ill. Rosemary had average mental ability which, later, made it easier for her to comprehend and adjust to the outcome of her illness.

Although she had not suffered from the usual childhood diseases, Rosemary had some knowledge of illness and hospitalization. At various times she had suffered from jaundice, pleurisy and a bout of hematuria of unknown origin. As a child she had had appendectomy and tonsillectomy performed. She had also had one miscarriage, and several cervical cauterizations made necessary by periodic bouts of abnormal bleeding. Each cauterization had been followed by normal menstrual periods. Her present admission became necessary when she developed a continuous flow of vaginal discharge which extended over a period of a month. She had slight abdominal pain and intermittent bleeding associated with this discharge.

Her physical condition was normal apart from the abnormal discharge. Laboratory examination showed normal findings in regard to urinalysis and blood count with a negative Friedman test. To establish a definite diagnosis, a biopsy was indicated. At the time of biopsy, a tumor was discovered in the cervix and a cervicectomy was carried out. The specimen was sent for microscopic examination and the pathological report indicated the presence of epidermoid or squamous cell carcinoma — a malignancy arising from the flat squamous cells covering the vaginal part of the cervix. To be certain that all malignant cells

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Miss Watanabe, who was a student at Misericordia Hospital, Winnipeg, was awarded a book prize for her study which received the third highest mark in the Macmillan Nursing Care Study competition.

are removed a complete removal of the uterus and its surrounding glands is imperative. This was the next step in the treatment and care of this patient.

Preoperative Nursing Care

The nursing care of a patient begins as soon as she enters the hospital doors. The nurse is the person with whom she first comes in close contact and from whom the patient gains her first and lasting impressions. Any patient, regardless of previous admissions, enters hospital with certain qualms although she may be most adept in hiding them beneath a cloak of external casualness. Calmness, cheerfulness, self-confidence and friendliness in the nurse inspires confidence on the part of her patient as well as gaining her cooperation. Rosemary was oriented to the routine of the ward, settled comfortably into bed and introduced to her room-mates. During the first few days that she spent in hospital, she underwent various tests and had a biopsy performed, all of which were accompanied by the explanation and reassurance necessary to produce a relaxed patient.

Rosemary's preparation for operation was quite extensive. Her meal the evening before the day of operation was light. While it is most essential that food and fluid intake be adequate, particularly prior to surgery, it is equally important that the gastrointestinal tract should be relatively free of contents at operation to reduce postoperative nausea, vomiting, distention and flatulence. For the same reasons, the nurse administered a saline enema shortly prior to operation. Vaginal cleansing with dettol solution, shaving and thorough cleansing of the skin area in and around the operative site helped to minimize the possibilities of infection postoperatively.

Preparation for operation should never be considered complete until the patient has been prepared mentally. Rosemary was worried about her coming operation and her mother's unsympathetic attitude did little to help her. She was intelligent enough to understand that she was not to blame for her physical condition, contrary to her mother's accusations, but resented her mother and was very much upset by her attitude. Rosemary had shown marked depression upon learning that she had a malignant condition and was subject to frequent crying spells. She was Roman Catholic by faith and a chat with the priest whom her husband had requested to see her helped substantially to put her mind at rest. Her doctor and her anesthetist visited her and explained the procedures which she would encounter in the operating room and the reason for the surgery. A good night's rest is most essential mentally and physically prior to surgery, so Rosemary was given morphine sulfate gr. ¼ to help relax her and accomplish this requirement. It is an accepted fact that the patient who is both mentally and physically relaxed is a better operative risk and less disposed to the development of shock.

On the morning of operation, her vital signs were checked once more and she received seconal sodium gr. 1½ at 6:00 a.m. followed by morphine gr. ⅙ and atropine sulfate gr. $\frac{1}{150}$ at 7:00 a.m. just before going to the operating room. The seconal sodium and morphine assisted in maintaining physical and mental relaxation, the atropine sulfate served to check excessive salivation and thus avoided possible atelectasis as well as assisting in minimizing postoperative nausea and vomiting. Rosemary's hairpins and jewellery were removed before she left her room, to prevent injury or loss while under anesthesia.

Surgical Report

A Wertheim hysterectomy was carried out. This entailed removal of the uterus and pelvic node resection. The specimen was sent to the laboratory and the pathological report indicated that the malignant growth had invaded the parametrium, vaginal wall and the body of the uterus through the endocervical canal.

Postoperative Nursing Care

Rosemary returned from the operating room under general anesthesia. Her condition was fair — blood pressure tended to be rather low, pulse and respirations rapid. An intravenous of 1000 cc. 5% glucose in distilled

water had been started in the operating room and was maintained on the ward with an additional 1000 cc. of 10% travert in normal saline. She was moved from the stretcher to a specially prepared recovery bed. Extra blankets were provided for additional warmth to help combat lowered body temperature. She was postured with her head turned to one side to prevent aspiration of mucus or vomitus. The airway was left in position until Rosemary reacted sufficiently to voluntarily expel it from her mouth. Leaving the airway in position restrains the tongue thus maintaining a free breathing passage. It must be remembered that under anesthesia voluntary control of the tongue is temporarily lost and it tends to drop back in the throat blocking the trachea.

The dressing over the wound was checked for any evidence of excess bleeding. Blood pressure, pulse and respiration rates were taken at regular intervals since changes in these readings may give the first signal of internal hemorrhage. As soon as Rosemary was conscious, the head of the bed was elevated so that she was in a semi-sitting position. This promoted drainage through the polyethylene tubing which had been inserted at the close of the operation to drain fluid and blood from the peritoneal cavity. This tube was opened at four hour intervals to allow the accumulation of fluid to escape. The nurse responsible for this used sterile equipment and aseptic technique to avoid the possibility of infection.

Crystalline penicillin, 1,000,000 units, was given every four hours for four days as a prophylactic measure. Morphine sulfate gr. $\frac{1}{6}$ was also given every four hours, as necessary, to alleviate pain. Since pain is thought to be a predisposing factor in the development of shock, controlling it is important.

Rosemary was encouraged to move her legs freely as soon as she could cooperate following her operation. This is very useful in preventing circulatory disorders — in particular, femoral thrombosis. Deep breathing exercises maintained adequate lung expansion and helped to prevent pneumonia. A few days after surgery she developed a slight cough for which she was given syrup cacillica compound drams 2, three times daily after meals and at bedtime. Early ambulation is an important factor in preventing postoperative circulatory disorders.

Rosemary sat on the edge of her bed and "dangled" her legs within 24 hours after her operation. On her fourth postoperative day she was allowed out of bed for a few minutes. She developed some discomfort from flatulence which was relieved successfully by the insertion of a rectal tube, and later, the administration of an enema containing magnesium sulfate, two ounces; glycerin, four ounces and water, six ounces. A mild laxative, magnolax, was given as needed during the remainder of her convalescence.

An indwelling catheter was placed in the bladder postoperatively. This avoided the danger of distention from a full bladder and possible disruption of the suture-line plus adding to the patient's general comfort. Pain at the site of operation, fear of pain, temporary loss of muscle tone due to anesthesia and operative handling or nervousness are all factors which may make it difficult for normal voiding to take place following an operation such as hysterectomy. Perineal care was given for the first few days postoperatively to add to Rosemary's comfort and further reduce the possibility of infection. The catheter was removed at the end of four days and the first normal voiding was noted and recorded as to time and amount.

Intake and output records were maintained immediately postoperatively to ensure that the patient received adequate amounts of fluid. This was essential from the point of view of fluid balance in the body and proper functioning of the urinary system.

Rosemary's convalescence was satisfactory and she was discharged two weeks after her operation. She will continue to convalesce at home until her physical condition permits her to return to her former work. With the help of her doctor and her husband, more satisfactory living arrangements have been made to allow her to rest and convalesce more effectively. Rosemary and her husband are looking forward to the adoption of a child to fill the place of the baby she cannot have herself.

Salt-losing Nephritis

D. Richards *and* R. Dodkin

The term nephritis shields a number of conditions possessing such varied clinical signs that they really appear as unrelated diseases. Years of research have failed to throw much light on the nature of nephritis. It is known that the kidneys show changes in each of the conditions, appearing pale with scattered punctate hemorrhages in acute conditions, enlargement in chronic states, and becoming small, red and scarred in the late stages. Salt-losing nephritis is one of the members of this diverse family. This discussion centres around John More who developed salt-losing nephritis when he was 39 years old.

At the age of 18, Mr. More had an attack of nephritis from which he made an apparently complete recovery within a short time. This demonstrates a few of the interesting facts about nephritis. It most often affects young persons, especially children, and males are much more susceptible to this condition than females. Over 95 per cent of the patients recover completely within a few days, although in some cases a period of months may elapse before recovery is accomplished. If recovery is complete, recurrence is rarely seen. In Mr. More's case recovery would seem to have been complete since he had no further difficulty for a period of over 20 years.

Early in 1955, Mr. More developed an illness during which he became quite jaundiced. From his personal history it was felt that he probably had had an attack of infectious hepatitis since another member of the family was ill with this condition at the time. Again recovery was uneventful and Mr. More returned to work. However, a few months later, he developed a dark red, blotchy rash on his arms and legs. His doctor placed him on antihistamine therapy with no apparent improvement. Mr. More was referred to a skin specialist who placed him on cortisone therapy and the rash disappeared. Unfortunately he developed a gastroenteritis with diarrhea one week later which he blamed upon the "doctor's pills." Upon admission to hospital at this time Mr. More exhibited abdominal distention with some type of obstruction which caused him severe pain. Blood chemistry indicated abnormalities in the amylase, thymol and zinc tests. An absence of estercholesterol which was thought to indicate severe liver damage, was also demonstrated.

Pancreatitis was considered as a possible diagnosis but clinical tests ruled it out. Since Mr. More's symptoms were becoming increasingly severe he was finally transferred to the Sarnia General Hospital for further investigation and treatment. Here gastric suction was established and fluid balance was maintained by intravenous therapy. His blood pressure and urea levels were found to be normal. The cause of the abdominal pain could not be determined exactly but acute cholecystitis was suspected and an operation was considered.

The laboratory director suggested that Mr. More's condition might be of a toxic nature and gave *Canicola fever* as a tentative diagnosis. This is a disease transmitted by dogs or rodents. It tends to produce abdominal pain, slight jaundice, an elevated white blood count and severe liver and kidney damage. As a result, operation was withheld and a lengthy investigation conducted at the end of which Mr. More's blood was found to be negative for Canicola fever. He gradually improved and was discharged from hospital. Several weeks later Mr. More had a dental extraction performed and subsequently became extremely ill. He was admitted to hospital where a diagnosis of *salt-losing nephritis* was made.

Signs and Symptoms

Mr. More complained of headache, the loss of sight in his left eye and

Mrs. Richards and Mrs. Dodkin presented the material in this paper in a clinic at the Sarnia General Hospital.

dyspnea. He exhibited fever, an elevated blood pressure, severe albuminuria, low blood urea and sodium content, and mental confusion. He was found to have left ventricular heart failure in addition. Both lungs contained a great deal of fluid and Mr. More had considerable discomfort from abdominal pain and distention. It was felt that he might have developed *periarteritis nodosa* — a disease characterized by abdominal pain in some instances, fever, weakness and cardiovascular disorders and which produces inflammatory and degenerative changes in blood vessels. In this instance Mr. More had a kidney infarction which accounted largely for the changes in his blood chemistry.

Treatment

Intravenous therapy with ansolysen was instituted to help reduce Mr. More's elevated blood pressure. It dropped from 220/152 to 142/128. Thoracentesis was performed to free the lungs of their accumulation of fluid and to facilitate breathing. Hydrocortisone was given since this preparation has been found to produce very good results in the treatment of periarteritis nodosa. It is preferred to cortisone since there is less disturbance of potassium and sodium levels.

Demerol and largactil diminished the pain and restlessness while oxygen therapy and aminophylline alleviated the dyspnea produced by the left ventricular heart failure. Regular insulin was added to the intravenous solution since Mr. More's potassium levels were high. The insulin combined with the sugar and potassium thereby reducing the amount of the latter in the blood stream. Electrolyte balance was maintained with specially prepared intravenous fluid and plasma. Penicillin 500,000 units was given twice daily prophylactically. It will be noted that all medications were given by other routes than the oral one since Mr. More could not take anything by mouth.

Pathology

It was very difficult to determine the exact diagnosis of Mr. More's condition. Terminal nephritis induced by the dental extraction or malignant hypertension were both possibilities. Periarteritis nodosa was thought to be definitely associated. The first two conditions invariably have a fatal outcome, the latter usually yields to therapy with hydrocortisone. Unfortunately the outcome in this case was fatal and upon post mortem examination it was discovered that Mr. More had suffered from 1) chronic nephritis and 2) periarteritis nodosa.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — Burnaby, B.C.: *Mrs. Moira Thomson* (St. Paul's Hosp., Vancouver). Hamilton: *Joan Tournay* (Toronto Gen. Hosp.). Lachine, P.Q.: *Christina Brunott* (St. Francisch Hosp., Holland). Lincoln-St. Catharines: *Sheila Malcowski* (Halifax Gen. Hosp.). Montreal: *Gayle Lightbody* (McMaster Univ.) and *Doreen Sawyer* (Montreal Gen. Hosp.). Preston, Ont.: *Mrs. Clara Weaver* (St. Mary's Hosp., Kitchener). Surrey, B.C.: *Mrs. Eileen Kelly* (Vancouver Gen. Hosp.) and *Mrs. Jean Maltby* (Soldiers' Memorial Hosp., Campbellton, N.B.). Saskatoon: *Mrs. Ruth Mullie* (St. Paul's Hosp., Saskatoon): Toronto: *Joan Van Nest* (St. Jos. Hosp., Toronto). Vancouver: *Hilda Evans* (North Staffs Royal Infirmary, Eng.), *Mrs. Donna Mort* and *Mrs. Vivian Yoder* (Vancouver Gen. Hosp.). Victoria: *Mrs. Mabel Lassen* (Royal Alex. Hosp., Edmonton) and *Jean MacDonald* (Hamilton Memorial Hosp., N. Sydney, N.S.).

Transfers — *Phyllis Farmer* to Regina, nurse-in-charge; *Mrs. Maude Grant* to Liverpool, N.S.; *Roberta Greig* to Surrey; *Grace Hill* to Trail, nurse-in-charge; *Marjorie Joyce* to Medicine Hat, nurse-in-charge; *Amy Keown* to Weston, Ont.; *Margaret McRae* to Lunenburg, N.S.; *Helen Servage* to Pembroke, nurse-in-charge; *Gloria Somerville* to Toronto; *Marion Van Noort* to Kentville, N.S. nurse-in-charge; *Mrs. Joan Wellum* to Hamilton.

Schizophrénie

Soeur Louis-Etienne f.a.s.p.

Histoire Personnelle

Mme Roy: Canadienne-française, catholique, âgée de 32 ans, était admise à l'hôpital en janvier 1952. Née en 1922, troisième d'une famille de cinq enfants. Naissance et développement normaux.

Antécédents physiques: Maladies en bas âge: rougeole, coqueluche, scarlatine, amygdalectomie (8 ans). Subhystérectomie à 28 ans.

Scolarité: A six ans, placée au couvent, à titre de pensionnaire, elle se sent rejetée, bien qu'elle eut là deux tantes religieuses qui furent d'une grande bonté et essayèrent par tous les moyens de la gâter. Elle ne put jamais chasser cette idée fixe: "Maman ne m'aime pas puisqu'elle m'a placée ici et qu'elle garde ma soeur à la maison." Dès ce moment, elle dit ne jamais avoir eu de bonheur, ni goût aux jeux, aux récréations, à l'étude, etc. Elle commença dès lors à être soupçonneuse et jongleuse, se tenant plutôt à l'écart. Son sentiment d'être rejetée l'empêcha de donner son attention à l'enseignement. Etant intelligente, elle réussit en dépit de son conflit. Elle quitta l'école à cause de la maladie de son père et commença à travailler à 14 ans.

Travail: Premier emploi dans une buanderie: trois mois. Après elle entra dans une manufacture de fourrures et y travailla six ans.

Milieu Familial

Mère: Personne autoritaire et surprotectrice à la fois, qui dépensait une grande activité pour le confort des enfants et l'entretien de la maison, tout en maintenant une atmosphère de malaise par ses récriminations à son mari et ses recommandations et reproches à ses enfants. Elle affichait une piété intempestive, pratiquait force dévotions extérieures, obligeant la famille à l'imiter, ce qui porta plutôt à s'éloigner de la religion et suscita maintes discussions.

Elle parlait beaucoup, énumérait à qui voulait l'entendre tout le bien qu'elle avait fait pour les siens; elle affirmait n'avoir rien à se reprocher et n'être nullement responsable si ses enfants n'étaient pas ce qu'ils devaient être. En somme, elle cherchait à se disculper.

Père: Maître de poste, homme sobre, intelligent, bon pour ses employés, mais qui fréquentait peu ses proches. Avait subi l'influence de son épouse, demeurait passif devant l'autorité de cette dernière. Décédait d'urémie en 1948. La patiente était plus attachée à son père qu'à sa mère.

Il est évident que tous les membres de cette famille vécurent les uns les autres dans un état de friction, de contradictions, de disputes et malaise, ce qui les poussait à quitter le toit familial à la première occasion. La patiente rapporte qu'auprès son travail, elle aurait voulu accomplir certaines tâches et que la mère s'interposait donnant comme raison qu'elle avait assez du travail à l'atelier; par ailleurs elle ne cessait ses réprimandes pour tout et rien.

Religion: A 17 ans, elle ne pratiquait plus. Vers la même époque son patron la menaçait de perdre son emploi si elle refusait ses avances; cette situation augmenta grandement ses difficultés intérieures. Son père mourut alors. Cette peine la porta à se replier sur elle-même et elle vécut un épisode de dépression. Elle relate: "Durant trois ans, je ne m'habillais que de noir, symbole de mon âme en détresse; j'avais perdu le goût de la vie."

Mariage: A 18 ans, un garçon lui inspira confiance, la fréquenta deux ans et l'épousa. Elle dit ne pas l'avoir aimé, mais avoir joui d'un sentiment de sécurité. D'ailleurs, c'était une bonne occasion pour fuir le toit familial. L'adaptation conjugale fut très pénible et laissa un souvenir désagréable à la patiente. Trois semaines

Soeur Louis-Etienne est une infirmière psychiatrique à l'Hôpital Saint-Jean-de-Dieu, Montréal.

après, son mari commença à la déserter. Il était vraisemblablement alcoolique et infidèle, ce qui porta Mme Roy à croire qu'elle n'était pas pour lui une véritable épouse et qu'à ses yeux, elle ne valait pas plus que la première femme qu'il eut rencontrée sur la route. Elle eut voulu qu'il aima assez pour en être jaloux. Elle croit que ce sentiment motiva la reprise de ses entrevues avec son ancien patron. Quand son mari lui manifestait quelques délicatesses, elle se sentait très coupable.

Début de la Maladie

A cette époque, elle devint enceinte. Elle se voyait incapable de briser sa liasion et sembla de plus en plus déprimée. A la fin de sa grossesse elle promit que si son enfant naissait en bonne santé, elle romprait coûte que coûte, ce qu'elle fit d'ailleurs.

Après la naissance de son fils, elle manifesta des troubles de comportement, accepta mal le surcroît de travail occasionné par celui-ci, et détesta de plus en plus le travail de maison. Malgré tout, elle se consacra à son enfant, avec l'idée constante qu'elle le laisserait pousser à sa guise sans contrainte, se rappelant toutes les frustrations dont elle avait souffert elle-même.

Elle essaya de combattre l'anxiété grandissante en fumant énormément et en faisant usage de somnifères, mais les symptômes s'installèrent graduellement. Elle consulta médecin après médecin pour divers symptômes, dans le but d'obtenir des calmants. Elle ne renouvelait jamais une première visite. Elle passait plusieurs jours sans manger pour se gaver les jours suivants. Elle buvait du thé exagérément. Elle fit des périodes d'agitation. S'enfuyait chez un membre de sa famille (mère-frère-soeur). A la maison, restait couchée, ne préparait pas les repas ni ne nettoyait la maison. La nuit, elle chantait à tue-tête. Elle menaçait son mari.

Elle tenta d'empoisonner son enfant de quatre ans avec des somnifères. Disait qu'elle voulait le faire disparaitre pour le soustraire à toutes les misères qu'elle avait subies elle-même. Ajouta qu'à sa prochaine tentative, elle ne manquerait pas son coup. Traitée à deux reprises dans une clinique psychiatrique, elle resta au plus trois semaines, et s'opposa à tous les traitements. Elle fut envoyée dans un hôpital psychiatrique sur l'avis d'un psychiatre qui la trouva dangereuse pour elle-même et son entourage.

Evolution de la Psychose

A son admission: Difficile, se plaint qu'on la détient injustement; dit qu'elle ne veut plus vivre avec son mari, à l'avenir, mais bien comme elle l'entendra:

Agitée — sans sommeil;
Hautaine — arrogante;
Tient des discours bizarres et incohérents;
Sens de l'auto-critique nul;
Croit que ses parents sont contre elle,
etc.

Diagnostic: Après les examens et observations de routine, l'assemblée médicale pose un diagnostic de: Schizophrenie (Type Schizoaffectif) et Mme Roy est dirigée dans une salle de traitements.

Traitements: Sédatifs, pour calmer l'agitation et l'insomnie; Electrochocthérapie; neuf traitements sans succès.

Après une certaine période, la thérapie convulsive fut reprise et cette fois, au cinquième traitement, la patiente s'étant améliorée, le médecin prescrit de l'occupation thérapeutique sous forme de travail domestique à la résidence des infirmières, donc en dehors de son département.

Tentative de suicide: Un matin à son travail entendant sonner le téléphone, elle croit que c'est pour la faire venir à son département pour recevoir un électrochoc, elle se jette en bas du troisième étage dans le but de s'infliger une blessure qui l'empêcherait d'avoir son traitement. Il en résulte une fracture. Elle explique cependant qu'elle n'a pas le désir de se supprimer.

Remise de cet état, son comportement se maintient plus calme, et elle obtient un congé de 15 jours qu'elle passe chez son frère. A son retour, interrogée par le médecin, elle affirme toujours désirer tuer son enfant qu'elle dit aimer. "J'ai été élevée de telle façon, mon enfant me ressemble, je me déteste et déteste en mon enfant ce qui me ressemble." Devient plus activement délirante par la suite. S'évade la nuit, dit qu'elle ne veut pas mourir

seule. Voit des signes. Partout, essaie de nouer des intrigues sentimentales. Croit qu'on veut l'empoisonner. Se sent poursuivre.

Veut tuer son enfant et pour cela écrit au médecin lui disant avec force détails, ses projets qui se résument à ceci:

> Solliciter la faveur de sortir afin de tuer mon enfant en lui assénant un coup, qui ne parviendrait pas à lui donner la mort instantanément mais que, conduit à l'hôpital, on serait impuissant à lui sauver la vie; elle voulait qu'il reçut tous les sédatifs nécessaires à lui supprimer ses douleurs. Durant ce temps, elle reviendrait à l'hôpital psychiatrique sans protester, attendant la nouvelle de la mort de son enfant. Elle croirait à cette mort seulement lorsqu'une photo le représentant dans sa tombe, lui serait remise, etc. Alors, elle aurait la "paix du coeur."

Cette lettre provoque chez les autorités médicales la décision de la changer de département où elle serait plus étroitement surveillée.

Amélioration: Ce changement de département joua un rôle très important dans la vie de cette malade. De cette époque les symptômes déclinèrent pour faire place à un comportement prometteur de guérison.

A son arrivée dans ce département, la patiente semblait à ce point atterrée, que le personnel s'en émut et redoubla de sympathie. Le contact s'établit dès les premiers moments et le transfert positif avec le médecin et l'hospitalière fut immédiatement établi. Utilisant ce critère, le médecin traitant de cette unité traça au personnel une ligne de conduite; lui-même accorda à la patiente de multiples entrevues où il appliqua une technique de psychothérapie intensive. Il s'agissait de redonner à cette personne l'amour et le respect d'elle-même et cela en lui en donnant beaucoup de la part de ceux qui l'entouraient.

Etant défiante à l'extrême et ne croyant à la sincérité de personne, il fallait toujours lui dire la vérité, et obtenir sa confiance. Le personnel lui témoigna un attachement réel qui finit par la convaincre qu'elle n'était pas si détestable puisqu'on pouvait l'aimer encore. Durant les premières semaines, la patiente continua d'écrire ses idées délirantes à sa mère. Petit à petit, Mme Roy se confia plus librement à l'hospitalière et aux infirmières.

Programme de Réhabilitation

On la dirigea vers l'occupation thérapeutique du département même. Elle accepta de confectionner des vêtements et accessoires de toilette pour elle-même. Elle éprouva une vive satisfaction dans la réussite de ces choses et était joyeuse de les montrer à sa famille, insistant sur le fait qu'on lui avait "donné" le matériel à l'hôpital, par conséquent, on lui portait de l'intérêt. Durant les entretiens, on lui laissait aborder ses propos bizarres et délirants, finalement elle en vint à juger elle-même de l'anormalité de vouloir tuer son enfant.

Au département, le programme d'activité suivait sa marche avec succés. De solitaire et incapable de communiquer avec les autres qu'elle était, elle devint de plus en plus sociable. Elle organisa des fêtes avec ses compagnes pour d'autres compagnes et fit des "surprise parties" pour le personnel, afin de suivre la tradition de ce département qui voulait qu'on marqua d'une réunion joyeuse, les anniversaires et les événements importants.

Ses tendances paranoïdes furent canalisées vers un but altruiste et son talent servit à composer chansons, rimes, adresses, compliments pour ces occasions. Sa bonne volonté et sa facilité à faire plaisir même aux plus dépourvues, aida à l'atmosphère thérapeutique de tout le département, plus d'une malade bénéficia de son influence. Elle collabora aussi au journal de l'hôpital et envoya dans un article, la description d'une réunion où elle avait prêté son concours.

Devant ces progrès, il fut décidé qu'elle visiterait son fils de temps à autre, accompagnée. Tout se passa de la manière la plus normale. De retour à l'hôpital elle discuta sensément du problème avec le psychiatre, il devint évident que le désir de tuer son enfant était disparu.

Elle dominait son besoin de rêverie par des distractions qu'elle réclamait dès qu'elle se sentait livrée à elle-même. Durant les entretiens, elle reconnut le besoin de dépendance qu'elle

éprouvait vis-à-vis de sa mère. Elle lutta pour s'affranchir de ce besoin et y réussit, ce qui fut pour la patiente une véritable révélation. Elle éprouva beaucoup de détente à se trouver libérée.

Attitude des siens: Durant ses sorties et au cours des visites de sa mère, celle-ci qui tentait encore de l'accaparer, fut surprise de voir Mme Roy prendre le dessus et ne pas céder dans les choses d'ordre ordinaire. La patiente de dire "je veux l'habituer graduellement, afin que, retournée dans mon milieu, je me sente libre d'agir. Si je suis trop douce maintenant, et m'affirme à ma sortie, on peut croire à une crise de colère ou à une rechute." Son mari assistait de loin à cette cure, voulait en douter, ne manifestait aucun encouragement à la patiente, souhaitant même visiblement une rechute. Frères: S'intéressaient visiblement à elle. L'aîné accepta de la recevoir et s'en rendit responsable quand le congé signé, elle partit de l'hôpital.

Adaptation à l'Extérieur

Elle alla vivre chez son frère, bientôt sa belle-soeur accepta mal sa présence. Elle trouva un emploi dans un atelier de fourrures, déménagea et organisa sa vie dans une chambre louée. Elle équilibra bien son budget, se tira parfaitement d'affaires, même si elle connut des difficultés. Son mari ne voulut pas reprendre la vie commune, essaya de l'interdire, elle s'opposa et obtint de la cour que la curatelle soit donnée à son frère; malgré tous ces tracas, elle ne développa aucune anxiété.

A son départ de l'hôpital, il fut entendu que son fils resterait aux soins de sa grand-mère paternelle et de son père. Elle consentit même à cet accord malgré la désir fréquent de le revoir; elle communiqua avec lui sous forme de colis qu'elle lui envoya de temps à autre. Elle sait que pour le moment cette situation est la meilleure, ne se sentant pas encore prête à reprendre cette responsabilité, elle réserve son énergie mentale pour plus tard, où elle espère lui donner un foyer harmonieux.

Visite l'hôpital assez souvent, garde des rapports cordiaux avec le personnel et le service social. Toujours, elle manifeste le goût de vivre, le désir de lutter pour sa subsistance et son équilibre. Elle a repris ses pratiques religieuses abandonnées depuis longtemps et mène une existence saine et rangée.

Résumé

Voici donc une personne dont l'incompréhension du milieu, aussi bien dans l'enfance que dans la vie d'épouse, apporta une détérioration de la personnalité au point de l'hospitaliser pour schizophrenie à la suite d'une tentative d'empoisonner son fils. Une technique sûre, suivie, menée par une équipe psychiatrique, combattit un à un chaque symptôme, pour aboutir à une resocialisation complète et un ajustement social aux problèmes suscités, lesquels furent maintenus même lorsque la patiente guérie, dut refaire une vie dans laquelle le mari déclinait ses responsabilités et essayait même de provoquer une faillite. Exemple encourageant d'un traitement de trois années apportant une récompense au-delà de toute attente.

Knowledge of the processes behind Migraine is gradually accumulating. The basic cause seems to be a constitutionally abnormal reaction to the release of histamine into the bloodstream. The several types of migraine apparently represent variant reactions of the external carotid artery to the released histamine. It is important to determine the form of the disease present in each individual before attempting treatment.

As far as treatment is concerned the priority of alleviation of the pain of the acute attack is emphasized. Simple analgesics, vasoconstrictors and vasodilators may provide this relief, sometimes dramatically. The next logical step is an attempt to prevent future attacks or at least decrease their frequency. The role of food allergy should not be overlooked. The migraine patient would do well to keep a dietary diary.

— *Scope Weekly*

Nursing Profiles

Annie Black Boyd, R.R.C., is now the director of public health nursing service with the Department of Health in Hamilton, Ontario. Excepting for her six years' leave of absence for service with the R.C.A.M.C. in World War II, Miss Boyd has faithfully served the citizens of Hamilton ever since her discharge from the army nursing service following World War I.

Very shortly after she graduated from Hamilton General Hospital in 1915, Miss Boyd went overseas with the C.A.M.C. She was awarded the Royal Red Cross, second class, after her years of service at base hospitals in France. Five years after she had joined the public health nursing staff in Hamilton Miss Boyd became a supervisor. She received the R.R.C. first class in recognition of her leadership as principal matron on the hospital ship *Letitia* during World War II.

Miss Boyd has been president of her own hospital alumnae association and also of District 4 of the Registered Nurses' Association of Ontario. She revels in the feel of the good earth as she tends her garden and enjoys equally making movies.

ANNIE BLACK BOYD

Sister Mary de Loyola, F.C.S.P., who was named director of nursing at St. Paul's Hospital, Vancouver, in October 1955, has had ample opportunity to polish up her bilingual skill as she has moved from east to west in various hospital positions. She began her nursing training at Hotel-Dieu, Montreal, then transferred to St. Jean de Dieu Hospital when she joined the Sisters of Providence in 1927. Her first graduate posting was as director of nursing at the hospital in Rivière du Loup, Que. Her first acquaintance with St. Paul's came in 1936 when she was made the supervisor of the medical floor there. Seven years later she was named superior of Notre Dame Hospital, North Battleford, Sask. During her term as administrator, the hospital was enlarged by the addition of a new wing to accommodate another hundred patients.

Transferred to Hôpital du Sacré-Coeur, Cartierville, as superior in 1949, Sister was responsible for the management of one of the largest hospitals in the Montreal area. It was during her regime there that she became a member of the American College of Hospital Administrators.

SR. MARY DE LOYOLA

Barbara Joan Small has taken up her duties as superintendent of nurses at the Manitoba School for the Mentally Retarded at Portage la Prairie, Man. A graduate of Winnipeg General Hospital, Miss Small has many avenues of interest that fit her well for her new work, in addition to her nursing background. She has musical training — both vocal and piano. She has been active in work with young people through her church affiliation. Previously Miss Small was engaged as a head nurse on the men's sur-

gical ward at W.G.H., then on the staff of the Hudson Bay Mining and Smelting Company Hospital at Flin Flon.

BARBARA JOAN SMALL

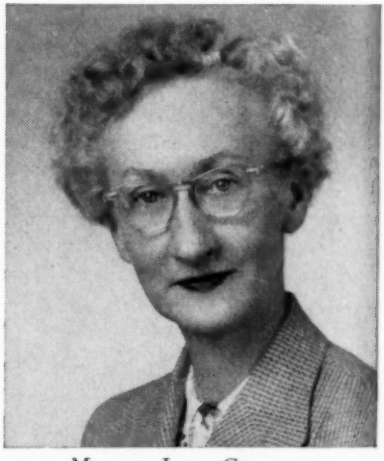
Dorothy Marcellus was appointed, early this year, to an exceedingly interesting piece of work under the auspices of the Ontario Society for Crippled Children. She is now assistant to Dr. H. O. Steer of the University of Toronto in the Cerebral Palsy Research Project which includes a study of the psychological aspects of the condition including the social, emotional and intellectual development of the affected children.

A graduate of the Toronto General Hospital, Miss Marcellus was on the operating room staff there for three years followed by a period of duty as assistant night supervisor. Distant fields called and for eighteen months she was in South America with the Imperial Oil Company. Private nursing kept her busy for five years following her return to Canada; then she went back to T.G.H. as head nurse in the fracture room in the Department of Radiology.

In the summer of 1949, Miss Marcellus joined the nursing staff of the Ontario Society for Crippled Children as superintendent of Woodeden Cerebral Palsy Centre, just outside London. Since that time she has devoted all her professional activity to the intensely engrossing work of the Mobile Unit of O.S.C.C. This unit has conducted a screening and diagnostic clinic for cerebral palsy, together with an assessment and parent instruction program, in various parts of Ontario. Having pioneered in the cerebral palsy program, Miss Marcellus is now one of the best informed nurses on this topic in Canada. Her new work will be watched with great interest.

(Skilling-Toronto)

DOROTHY MARCELLUS



MURIEL JEAN GRAHAM

Muriel Jean Graham, who is the director of the School for Nursing Assistants, Camp Hill D.V.A. Hospital, Halifax, has had a wide variety of exciting professional roles since she graduated from Victoria General Hospital, Halifax, some 24 years ago. Her first assignment was as registrar and executive secretary with the Registered Nurses' Association of Nova Scotia. She relinquished this post to enlist with the R.C.A.M.C., serving overseas 1941-45. She was chosen as a nursing consultant with UNRRA and worked in China for two years. A less demanding interlude followed during which

she was educational director and assistant superintendent of nurses in the Children's Hospital, Halifax. Again the tide of events swept her away to new challenges as a nursing instructor in a WHO assignment to Rangoon, Burma. She returned to Halifax in 1954 and served as director of nursing at Children's until she assumed her present duties.

Helen Neil McCallum is initiating a new program for the Nursing Branch of the Ontario Department of Health as its first consultant in hospital nursing service. A graduate of the Hospital for Sick Children, Toronto, and holding her certificate from the University of Toronto School of Nursing in nursing education and administration, Miss McCallum has had many years of hospital experience as background for her consultative duties. She served as a head nurse at the Montreal Children's Hospital for some time before returning to her own hospital as assistant night supervisor. For the past six years she has been senior clinical instructor at HSC following ten years as medical supervisor. Among her hobbies, Miss McCallum lists a love to travel. There is no doubt that she will have ample scope for this urge in her new work.

(Peggy Todd-Toronto)

HELEN NEIL MCCALLUM

Helen Christena Wilson has retired from active nursing after more than thirty years of service, much of it in her own school of nursing, the General Hospital, Cornwall, Ont. Staff nurse then x-ray supervisor, Miss Wilson became director of nursing there in 1938. Seven years later she accepted a similar position at Soldier's Memorial Hospital, Campbellton, N.B. She returned to Ontario and served as superintendent of Winchester District Memorial Hospital until her retirement. She now resides at Lunenburg, Ont.

In Memoriam

Mary Gretchen Allison, who graduated from Royal Victoria Hospital, Montreal, in 1920, died on April 17, 1956. She had engaged in private nursing during her active professional life.

* * *

Alma Douglas, who graduated from the General Hospital, Woodstock, Ont., in 1919 died recently at Toronto.

* * *

Hilda May Dyer, a member of the first class to graduate from the General Hospital, Swift Current, Sask., died at Victoria on February 29, 1956. Miss Dyer had worked continuously in the Swift Current area, engaging in staff or private nursing, until her retirement in 1952.

* * *

Annie M. Forrest, who graduated from Winnipeg General Hospital in 1907, died on April 4, 1956 at the age of 81. Miss Forrest served overseas during World War I. She was superintendent of nursing at the Queen Alexandra Sanatorium in London, Ont., for many years prior to her retirement in 1933.

* * *

Margaret Ann Gavin died at Brockville, Ont., on April 4, 1956 at the age of 86. Active in nursing in the Brockville area, Miss Gavin had been retired for many years.

* * *

Mary Goldhawk died at London, Ont., on April 29, 1956. Until a very short time before her death Miss Goldhawk was a plant nurse with The Canadian Bridge Company at Walkerville, Ont.

* * *

Sarah Annie Le Good, who graduated from St. Boniface Hospital in 1923, died at Souris, Man., on February 15, 1956 after an illness lasting 15 years. She was 56 years of age.

* * *

Grace McKeever, who graduated from

Winnipeg General Hospital in 1921, died there suddenly on April 15, 1956. Miss McKeever was formerly superintendent of nurses at Manitoba School, Portage la Prairie.

* * *

Bertha Lynetta Mallory, a graduate from Ogdensburg, N.Y., died at Caintown, Ont., on February 18, 1956, in her 67th year.

* * *

Mary Elizabeth Moody, a graduate of New York General Hospital, died at Huntington, Que., on February 21, 1956, following a long illness.

Céline Moore, who graduated from Hôpital St. Luc, Quebec, in 1931, died on March 3, 1956 at Ste. Marie de Beauce. She was formerly on the staff of the hospital at Ste. Anne de Bellevue.

* * *

Helen L. (Sheldon) Poetschke, who graduated in 1930 from the University of Alberta Hospital, Edmonton, died on September 9, 1955.

* * *

B. (Collier) Smith, who graduated in 1908 from Medicine Hat General Hospital, died on September 20, 1955.

Sélection

Une innovation qui pourrait réduire les coûts de construction des hôpitaux.

Il est possible qu'en construisant son nouvel hôpital général de 250 lits, la ville de Niagara Falls (Ont.) ait trouvé un moyen de diminuer les coûts toujours croissants de l'hospitalisation.

D'une conception nouvelle, l'hôpital comprend un immeuble central de trois étages et des ailes moins coûteuses d'un seul étage. On estime que la grande efficacité de l'immeuble à plusieurs étages de l'hôpital conventionnel n'est pas nécessaire dans le cas de la majorité des malades qui, une fois le stage critique de leur maladie passé, peuvent être soignés dans une aile moins coûteuse de convalescence. On prévoit que cette idée entrainera une économie d'environ $3,000 par lit dans le coût général de la construction.

En outre, le transfert du malade à l'atmosphère d'optimisme de l'aile de convalescence peut réduire la durée du stage à l'hôpital et, partant, les coûts qu'il entraine. Extrait de la *Gazette du Travail,* février 1956.

Les méfaits du bruit et leurs répercussions sur l'organisme humain.

Les médecins ont presenté, devant l'Académie Nationale de Médecine de Paris, un exposé très précis sur les méfaits du bruit et leurs répercussions sur l'organisme humain.

Les auteurs, après avoir rappelé quelques notions fondamentales relatives aux diverses modalités d'action du bruit et des vibrations, montrant comment, en affectant l'appareil auditif et par-delà l'oreille, le cerveau et le système nerveux, cette action provoque des chocs, des traumatismes cérébraux et des réflexes émotifs qui se répercutent singulièrement sur la santé des humains.

Des troubles, des manifestations pathologiques et même certaines affections organiques peuvent apparaitre ou s'aggraver sous l'influence du bruit et des trépidations et les auteurs citent des exemples.

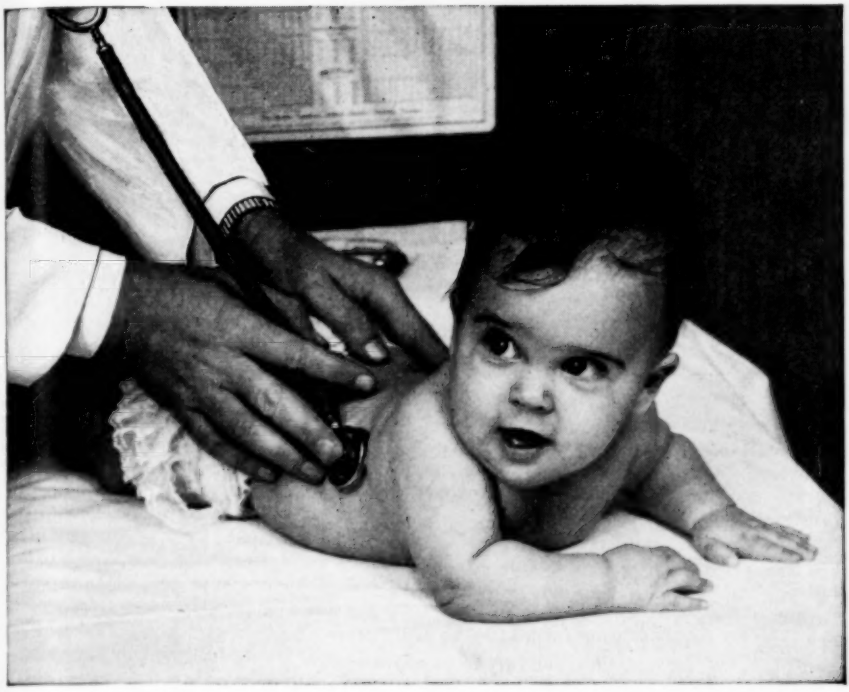
Il s'ensuit que, médicalement, une lutte opiniâtre doit être menée contre "ce nouveau danger social."

Extrait de *Information médicale et para médicale,* de Montréal.

A new treatment has been developed for patients with liver disease who become mentally confused or stuporous and show symptoms of impending coma. Hepatic coma has long been a confusing syndrome. It occurs suddenly — the patient becoming unduly drowsy and speaking with slurred or thick speech. A period of noisy confusion and delirium is followed by unconsciousness.

In certain patients this chain of events can be broken by L-glumatic acid. These are people (chronic alcoholics for the most part) in whom hepatic coma is precipitated by a high protein diet, treatment with a diuretic or sudden gastrointestinal bleeding. The badly damaged liver cannot stand the additional strain and the individual becomes confused and disoriented. The same drug also produces good results in the cirrhotic patient who shows definite but mild neurological symptoms over an extended period without improving or regressing into permanent coma. Under such circumstances normal mental status has been consistently restored.

— Communications Associates



"Better physical condition when fed meat early . . ."

IN a study conducted by Leverton and Clark "Meat in the Diet of Young Infants", (J. A. M. A., *134*,1215 (1947), special prepared meat was added to the formula of full-term babies beginning at the age of six weeks and continuing for a period of eight weeks. The pediatrician in charge considered that the babies were in better physical condition generally as a result of the meat supplement. Nurses in attendance reported that the meat-fed infants seemed better satisfied, slept well and cried little.

Swift's Meats for Babies was the original product of this kind placed on the market. Prepared from only fine, lean meat, the food is cooked and milled to a fine purée. The texture is soft, moist and easily fed in formula or for initial spoon feeding just as it comes from the can. There are seven kinds for variety and special conditions: Beef, Lamb, Pork, Veal, Liver, Heart, Liver and Bacon, and also Swift's Egg Yolks for Babies, Salmon Seafood for Babies and the chopped Swift's Meats for Juniors.

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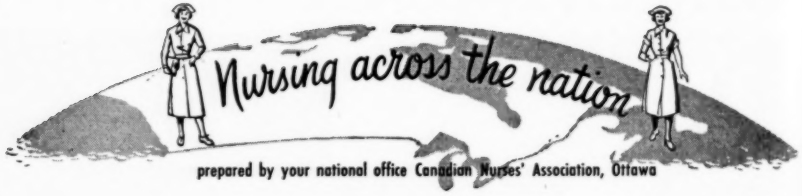


Nursing Progress in 1955

SEVERAL MONTHS AGO we mentioned in this column that the CNA had been asked to submit a contribution for *The Yearbook of Modern Nursing* published by G. P. Putnam's Sons, New York. Early in May, we received a copy of this book in National Office. A collection of contributions from representatives of leading nurses' organizations, national and international, it gives a valuable, up-to-date picture of nursing events over the past year.

Important unpublished papers used in conferences, workshops and panel discussions are also included. Its pages are crammed full of important information about nursing in 1955. The price is $4.95, the Canadian publisher is McAinsh & Co. Ltd., Toronto.

Canadians Abroad

In May, two well-known Canadian nurses were in Geneva attending the 9th World Health Assembly. Attending as official nurse representative in the Canadian delegation was Miss Dorothy Percy, chief nursing consultant, Department of National Health and Welfare. Those fortunate enough to attend the Biennial Meeting will recall hearing Miss Percy speak of the Technical Discussions on *Nurses: Their Education and Role in Health Programs.*

Also present was Miss Alice Wright, executive secretary and registrar of the R.N.A.B.C. Earlier in May Miss Wright attended a meeting of the ICN Membership Committee in Copenhagen. Following this she visited nursing associations in Great Britain, Holland, Belgium and Germany.

Diversified Audience

The CNA brief to the Royal Commission on the Economic Future of Canada is having wide distribution. One hundred and seventy-five copies have been sent out from National Office. Almost daily, requests are being received from nurses, members of parliament, libraries, universities and University Women's Clubs.

National Office Staff and Annual Meetings

Your National Office staff has had the pleasure, this spring, of attending provincial annual meetings in Toronto, Montreal, Regina, Nanaimo and Banff. Our General Secretary unhappily had to forego the pleasure of being present at the Newfoundland meeting. After three attempts, poor weather conditions finally won out and her trip was cancelled. The chance to visit the provinces and meet with members of the CNA is always a welcome one.

33 Price Street

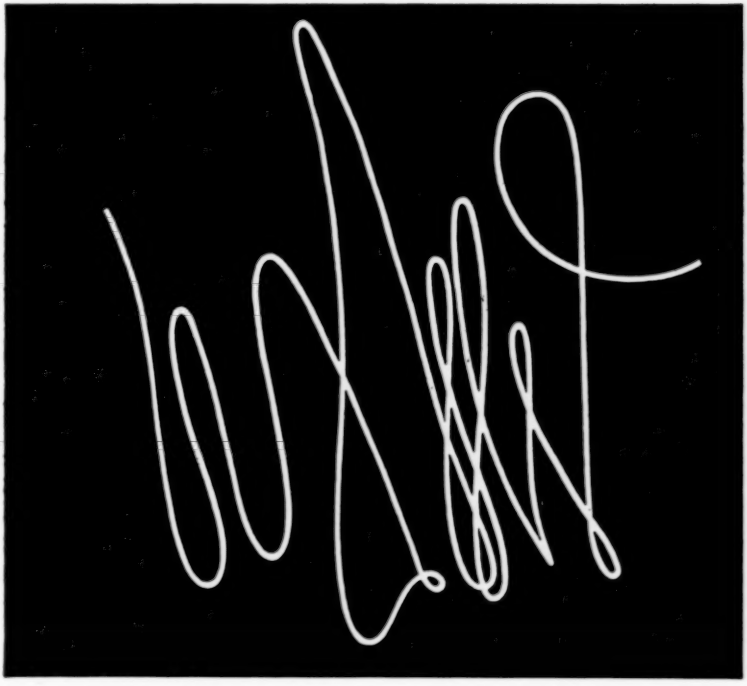
The second provincial nurses' association to build a home of its own held an impressive ceremony on May 11. A special guest, in the person of Miss Daisy Bridges, executive secretary of the International Council of Nurses, officiated at the laying of the cornerstone for the new R.N.A.O. building. Miss Bridges was on this continent to present an address at the American Nurses' Association Biennial Meeting in Chicago.

The above street number, as you've guessed, is in Toronto and will be one to make note of when next fall the R.N.A.O. moves to its new quarters.

The first association to build its own home was, as you know, the R.N.A.B.C.

Dalhousie Serves the Maritimes

The school of nursing of Dalhousie University once again brought Mari-



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time nurses together for a pooling of experiences and ideas. During the last week in April a refresher course on *Administration and Supervision in Nursing Education* was conducted at Dalhousie University under the able leadership of Mrs. Genevieve K. Bixler, presently director, Nursing Education Project, Southern Regional Education Board, Atlanta, Georgia. Registration was limited and only those who had had at least one year of University study were allowed to attend.

The pattern which the institute followed was that of a presentation on one major area of nursing education in the morning, followed by reading periods and discussion groups in the late morning and afternoon. The last afternoon was devoted to reports from the groups in which conclusions and recommendations were presented. Although each discussion topic was on a different major aspect of nursing education, two main conclusions were made evident. Without both a thoughtful and continuous system of evaluation and dynamic staff education program, curricula no matter how carefully planned and executed, cannot approach their maximum effectiveness.

Mrs. Bixler, a research consultant with many years of orientation to nursing education contributed generously both during the planned sessions with the entire group and by individual consultation. As all who are interested in nursing education know, she is co-author with her husband, Dr. Roy W. Bixler, of the book *Administration for Nursing Education.*

The Registered Nurse in Mental Health

The Mental Health Division of the Department of National Health and Welfare has released a new pamphlet *Opportunities for Registered Nurses in the Mental Health Field.* One of a series of publications for the recruitment of professional workers for psychiatric hospitals, clinics, and other services, it is aimed at interesting high school students in entering psychiatric nursing following graduation from schools of nursing. It should be useful to vocational guidance officers, instructors in schools of nursing and to registered nurses generally. Requests for copies should be directed to provincial departments of health.

Our Visitors

We are always happy to have visitors from other countries. Among those who have visited us recently are Miss Nancy Dixon, deputy superintendent of the Queen's Institute of District Nursing, London, England and Miss Dorothy Thomas, assistant matron of the Middlesex Hospital, London, England.

Miss Dixon was naturally very interested in visiting nursing and spent most of her time with the Victorian Order of Nurses visiting the Head Office in Ottawa and several branches in Montreal, Toronto, Hamilton and the Niagara Peninsula. She was particularly interested in the in-service program on rehabilitation which the V.O.N. conducts for its nurses.

Operating theatres, central supply service and nurses' residences were Miss Thomas' main interest and she visited many hospitals in Montreal, Toronto and Ottawa.

These nurses are loud in their praise of the hospitality, interest and cooperation of the many nurses who spend so much time in making the visits of our international visitors so interesting and informative.

National Office is particularly grateful to the nurses who are members of the Canadian Nurses' Association Women's Auxiliary here in Ottawa who volunteer to drive these visiting nurses around the city so that they may see as much as possible of its beauty and the principal places of interest in the short time that they are in the National Capital.

The measure of a man is not the number of servants he has, but the number of people he serves.

It is a pleasant thought that when you help a fellow up a steep hill, you get nearer the top yourself.

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Le Nursing à travers le pays

Progrès en Nursing en 1955

Il y déjà plusieurs mois, dans ces colonnes, nous vous faisions part que l'A.I.C. avait été invitée à envoyer un article sur le Nursing au Canada pour être publié dans "The Yearbook of Modern Nursing," édité par G. P. Putnam's Sons, New York. Ce livre présente un tableau du nursing actuel et rapporte les principaux événements de l'année dans ce domaine. C'est une compilation d'articles écrits par des représentants des principales organisations en nursing, tant à l'échelon national qu'international.

On y trouve également le texte de conférences, de colloques et de discussions de groupes. Le volume est en vente chez McAinsh & Co. Ltd., Toronto, au prix de $4.95 l'unité.

Canadiennes outre-mer

En mai, deux infirmières canadiennes bien connues étaient à Genève où elles assistaient à la 9ième réunion de l'Organisation Mondiale de Santé. Mlle Dorothy Percy, consultante en chef en nursing au Ministère de la Santé Nationale et du Bien-être, conduisit la délégation canadienne. Les infirmières qui ont eu l'avantage d'assister au Congrès de Winnipeg se rappelleront avoir entendu Mlle Percy parler sur: Les infirmières, leur formation et leur rôle dans un programme de santé.

Mlle Alice Wright, secrétaire registraire de l'Association des Infirmières de la Colombie Britannique, était aussi présente à cette réunion; auparavant, elle avait assisté à une réunion du Comité des membres du Conseil International des Infirmières à Copenhague. Mlle Wright visita plusieurs associations d'infirmières en Grande-Bretagne, en Hollande, en Belgique et en Allemagne.

Lecteurs variés

Le mémoire présenté par l'Association des Infirmières Canadiennes à la Commission Royale sur l'avenir économique du Canada est en grande demande. Le Secrétariat National en a expédié 175 exemplaires. Tous les jours nous recevons de nouvelles demandes venant d'infirmières, de députés, de bibliothécaires, d'universités et d'organisations féminines.

Le personnel du Secrétariat National et les assemblées annuelles

Les membres du Secrétariat National ont eu le plaisir, au printemps, d'assister aux assemblées annuelles d'associations provinciales à Toronto, à Montréal, à Régina, à Nanaïmo et à Banff. Notre secrétaire générale a dû renoncer au plaisir d'assister à la réunion des infirmières à Terreneuve car, après trois essais infructueux, le voyage dut être décommandé à cause de la mauvaise température.

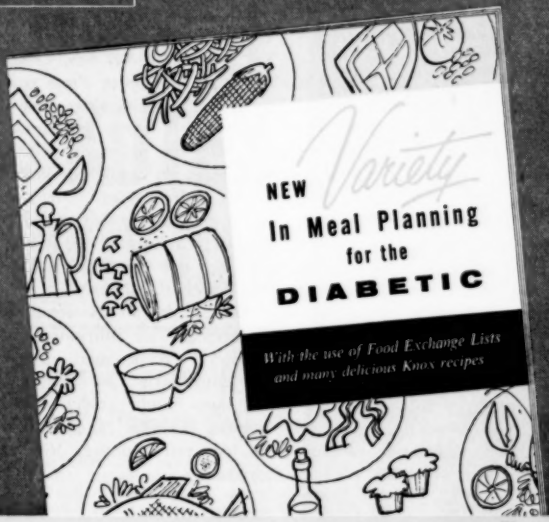
Le 33 de la rue Price

Pour la deuxième fois, une association provinciale vient de décider de se construire une maison. Une cérémonie imposante eut lieu le 11 mai à Toronto alors que Mlle D. Bridges, secrétaire du Conseil International des Infirmières posa la pierre angulaire de l'immeuble qui abritera l'Association des Infirmières de l'Ontario. Mlle Bridges était en Amérique à l'occasion du Congrès Biennal des Infirmières américaines, à Chicago, auquel elle devait adresser la parole. La première association d'infirmières à construire ses propres quartiers fut celle de la Colombie Britannique.

L'Université de Dalhousie au service des Provinces Maritimes

L'Ecole d'infirmières de l'Université de Dalhousie a encore une fois réuni les infirmières des provinces maritimes pour leur permettre de mettre en commun leurs expériences et leurs idées. Durant la dernière semaine d'avril, un cours de perfectionnement sur l'Administration et la Surveillance dans l'Education des Infirmières fut donné à l'Université. L'inscription en était limitée aux infirmières ayant fait une année d'études universitaires. Voici le programme du cours: au début de l'avant-midi, présentation d'un communiqué important sur l'éducation, suivie d'une période de lecture et de discussion en groupe, se prolongeant dans l'après-midi. Au cours de la dernière après-midi, les rapports, les conclusions et les recommandations furent présentés. L'éducation en nursing fut considérée sous divers aspects, mais on en est venu à la conclusion suivante: Le programme d'études, si bien préparé et exécuté

KNOX Protein Previews



Newest Knox Brochure
Aids Dietary Management of Diabetics

The new Knox booklet "New Variety in Meal Planning" has been prepared to help you enlist the patient's enthusiasm for dietary measures and to help maintain this enthusiasm. It explains the importance of diet to the diabetic, shows him how to use the newest dietary advance—Food Exchange Lists[1]—and then describes how to provide tasty variety with 14 pages of tested, diabetic recipes.

"New Variety in Meal Planning" makes no attempt to prescribe a system of treatment. It shows how the recipes described may be used to good advantage in practically any system of diabetic management. If you would like a supply for your own use, fill in the coupon below.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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soit-il, ne peut donner son maximum d'efficacité qu'à la condition d'être continuellement évalué et appuyé par un programme dynamique d'éducation du personnel. Mme Bixler, consultante en orientation dans le domaine de l'éducation en nursing, a contribué généreusement au succès du cours. Elle est l'auteur, conjointement avec son mari le Dr. Roy W. Bixler, du livre intitulé: "Administration for Nursing Education."

L'infirmière et la santé mentale

Le Service de l'Information du Ministère de la Santé Nationale et du Bien-être social vient de publier un feuillet intitulé: "Avantages offerts aux infirmières en hygiène mentale." Ce feuillet fait partie d'une série de publications ayant pour but le recrutement du personnel professionnel dans les hôpitaux psychiatriques, cliniques, etc. Il s'adresse aux étudiantes des écoles supérieures afin de les intéresser au nursing en psychiatrie advenant le cas où elles se dirigeraient vers la profession d'infirmières, une fois leurs études terminées.

Nos visiteuses

Il nous fait toujours plaisir de recevoir des visiteurs de pays étrangers. Récemment, nous avons eu la visite de Mlle N. Dixon, directrice adjointe du Queen's Institute of District Nursing, de Londres, Angleterre, et Mlle D. Thomas, assistante de la directrice du Middlesex Hospital, de Londres également. Mlle Dixon était tout particulièrement intéressée à visiter les organisations d'infirmières visiteuses. Elle a visité les quartiers généraux du V.O.N. à Ottawa et le service de la même organisation à Montréal, Toronto, Hamilton et Niagara. Le service hospitalier à domicile des malades, fait par les infirmières du V.O.N. et leur réadaptation ont été l'objet d'une étude particulière.

Mlle Thomas a visité plusieurs hôpitaux à Montréal, Toronto et Ottawa, dans le but de voir les salles d'opération, le service central et les résidences des infirmières.

Ces visiteuses ont fait beaucoup d'éloges de la généreuse hospitalité qu'elles ont reçue durant leur séjour au pays ainsi que de l'intérêt que leur ont manifesté un grand nombre d'infirmières.

Le Secrétariat National remercie particulièrement les infirmières membres de la section des dames auxiliaires de l'Association des Infirmières Canadiennes, à Ottawa, qui ont bien voulu conduire nos visiteuses à travers la ville et dans les environs afin de leur faire admirer les beautés de notre capitale.

In the Good Old Days

(*The Canadian Nurse* — JULY, 1916)

A survey of 403 practical nurses working in Detroit revealed that a great many were rejected probationers from hospital schools. They objected to the rule that they must not wear white uniforms as they wished to be called "trained nurses." They are by all odds the most difficult type to deal with.

* * *

The highest medical authorities have finally agreed that cancer does not result from a germ but from some unknown form of body poison which spreads through unhealthy tissue suited to its propagation and ultimately destroys that tissue.

* * *

Canadian nurses in the C.A.M.C., with their lieutenant's rank, mixed things up a bit at first as military discipline as usually applied to officers of that rank was a misfit. English nurses do not have as much freedom of action as do the Canadians. They would never be allowed the liberty of dancing or of having afternoon tea with the male officers at the Sisters' Mess.

* * *

Great pleasure was expressed that the new nurses' residence of the Vancouver General Hospital was available for the reception following this year's graduation. It is a magnificent building.

* * *

Laws are needed to regulate the practice of nursing. They reflect the character and intelligence of the people. The time is ripe for legislation to protect the fully qualified graduate nurses.

* * *

Some of our nurses have been taking bicycles over from England for use behind the lines in France. French firms are too busy making munitions to manufacture bicycles.

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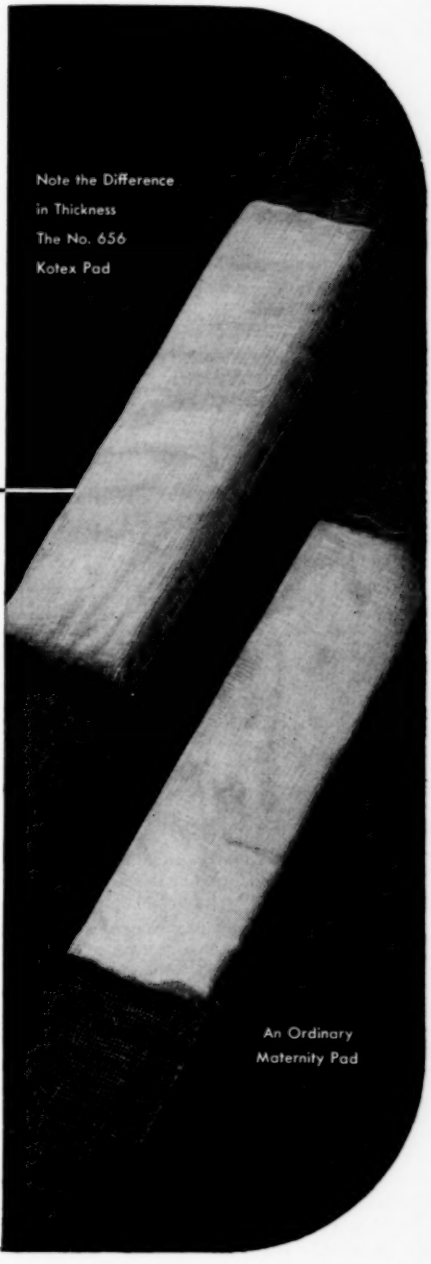

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- **Rounder, softer edges for greater comfort to patients.**
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Book Reviews

Nursing Practice and the Law, by Milton J. Lesnik and Bernice E. Anderson, R.N., Ed.D. 384 pages. J. B. Lippincott Company, 2083 Guy Street, Montreal, P.Q. 2nd Ed. 1955. Price $6.00.

Reviewed by Miss Lola Wilson, Secretary-Registrar, S.R.N.A., Regina.

Although this book is written and illustrated from various cases involving nurses in the United States, it contains a wealth of material that could be read with benefit by all nurses in Canada. As one reads it, one must continually bear in mind that what is written in the laws of the United States at the federal level or at the state level, may not necessarily apply in Canada or in specific provinces in Canada.

There are three chapters in this book that are of particular interest. Chapter IV deals with "Legal Control, Nursing Practice Acts: Analysis and Evaluation." The authors state in the very beginning of this chapter that "Legal control over a profession requiring skill and education for its adequate performance is based upon the police power of the state to secure the people from incapable, deceptive and fraudulent practitioners." The chapter deals with current legislation in the United States and the nursing Acts relative to the various states in the United States with special reference to the appendices, spelling the early Acts out in full. The entire chapter contains a challenge for every registered nurse to work toward more effective legislation for nurses. The following statement in this chapter, "The contribution of an effective administrative agency to secure the public will be related directly to the extent of knowledge, wisdom and experience of its members" is one that we, the registered nurses of Canada, cannot ignore.

The chapter relative to "Contracts for Nursing Services" bears careful review. The continual mention of the implied contract throughout this chapter brings very acute awareness of the responsibility of nurses to fully acquaint themselves with the implications of agreements they may make in relation to service.

The outstanding chapter in the entire book, in our opinion, is the one dealing with "Legal Aspects of Negligence and Malpractice." This chapter is not only an attempt on the part of the writers to impart information relative to negligence and malpractice, but also to stimulate nurses to accept the fact that if we are to be classified as a professional group, we must assume our own professional responsibilities. Such statements as "The security of a profession is identity." "The majority of malpractice actions involving nurses relate to injuries sustained as the result of the failure to do something," etc., make one ponder. Nursing must assume its professional responsibilities but, in assuming them as a group, we must recognize that it is the *individual* who is most likely to be called upon to answer for her actions in a court of law. We must be certain that the individual is fully aware of the legal implications of professional practice and that she understands that she is responsible for her own actions. We, as an organized profession, are responsible to society and to professional nurses in making a real effort to more carefully define what professional nursing practice is.

Time and again it is emphasized that we must define the functions of professional nursing. Research is necessary so that this can be done. Although we have entered into the realm of an accepted profession, the authors state that nurses still entertain the fallacy that they are absolved automatically from liability by performing and executing an order of a licensed physician. The authors point out that no person may absolve another of liability and that no physician may order a nurse to perform an act and assure her that he will assume full responsibility. They state "The nurse who acts pursuant to such an understanding, without an appreciation of the cause and effect of the order she is to execute, renders herself and the patient a disservice. The law is clear that a nurse is required to understand the procedure or technique she is directed to apply." The entire chapter points to the need for a clearer definition of professional nursing functions and as an immediate result, therefore, a clearer definition of the role and function of the practical nurse (in Canada, the generally accepted term is "nursing assistant") group.

This book is well written and very easily understood. Regardless of the fact that it may refer on the whole to nursing practice in the United States, the basic concepts and principles dealt with do not differ from Canada. In our opinion this is a book to be read with benefit by every nurse.

News Notes

ALBERTA

District 3

Banff

A busy round of activities has been planned by this chapter. The Baby Clinic, held monthly, reports a good attendance. A film showing under the auspices of the Cancer Society was held in April. Mrs. Lister, at a recent meeting, gave an excellent report of the Cancer Workshop which she had attended as group representative. The Bursary Committee has completed the wording of and the regulations governing the award of the chapter bursary to a girl choosing nursing as a career. The presentation of the award is to take place in June. Tentative plans are in progress to hold a public speaking course in the fall.

To allow members to attend the conference held at the School of Fine Arts, the chapter voted the funds necessary to pay the registration fee to the Alcoholism Foundation. It afforded an excellent opportunity for those interested in acquainting themselves with the problems created by alcoholism to increase their knowledge.

To offset the hazards produced by tourist travel and the usual large influx of visitors, members have arranged to assist in the event of large scale accidents or other emergencies and have been mobilized into teams of five with one nurse responsible for keeping the other members of her group informed.

Calgary

Members received some very good advice on how to invest their money at a recent meeting. Mr. J. V. Sorsliel of Nesbitt Thomson Investment Co. was the guest speaker at the supper meeting.

Vulcan

The past year has been an active one for this chapter. A series of civil defence lectures, demonstrations and films under the direction of Mr. Wm. Shields formed an important part of the educational program. Home nursing classes are being continued. The Shut-In Project which took the form of provision of a TV set for a patient at home with a long-term illness is proving to be a source of great pleasure and satisfaction. The Blood Donor Clinic has received considerable assistance.

District 4

Medicine Hat

Several delegates represented the chapter at the annual provincial convention in Banff. A rummage sale was held in February

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with considerable success. Mrs. Currie and Mrs. Skinner discussed the Council of Social Service in the city as guest speakers at one recent meeting while Dr. Van Belkum was a welcome guest and speaker at another.

Red Deer

Executive officers for the current year are: Mrs. Pollock, pres.; Mrs. McKeown, vice-pres.; Miss Yuill, treas.; Mrs. Flegal, rec. sec.; Mrs. Forbes, corr. sec. Guest speakers during the early part of this year have included Dr. R. Chadwick who pictured for his audience some of his experiences while living and working in China, and Mr. Sinclair, president of the Twilight Homes Foundation.

District 7

Grande Prairie

Members elected to the executive for the current year include: Mrs. K. Murray, pres.; Mrs. M. Martin, vice-pres.; Mrs. B. Butchart, sec.; Mrs. M. Orr, treas. This chapter reported a very active year during 1955. Programs were based around civil defence developments, private duty nursing and other timely topics.

Stony Plain

The following members were elected to office for the current year: B. Cogland, pres.; Mrs. S. Mills, vice-pres.; Mrs. J. Wood, sec.-treas. The programs presented during the early part of this year have been most interesting and have included the story of antibiotics as portrayed in the film "The Earth Shall Give Back Life"; a description of the care of the patient with a colostomy and a summary of information relating to new drugs recently introduced into general use. A visit to the Cerebral Palsy Centre was very much appreciated by those attending.

A donation was sent to the Unitarian Service from this chapter to aid Greek Red Cross nurses. Members assisted with the local Red Cross canvass. The guest speaker, Mr. Howie, gave a most interesting and enlightening address on the legal aspects of nursing as related to "The Legal Rights of Married Women," at one of the chapter meetings.

A visit to the Cerebral Palsy Clinic, Edmonton, highlighted a spring meeting of this chapter. The group visited each department of the Clinic and the various staff members discussed their work informally and answered questions. Mrs. H. Meicklejohn was the official delegate to the annual meeting of the A.A.R.N.

Wainwright

Members elected to the executive for the current year were: Mrs. R. Wallace, pres.; Mrs. M. Middlemass, vice-pres.; Mrs. I. Harick, sec.-treas. A midwifery kit was sent to "CARE" as a chapter project. During the past year members have enjoyed a varied and interesting program of activities ranging from cerebral palsy, cancer and cancer research and infectious hepatitis to guidance clinics. The Blood Donor Clinic and Cancer Drive received assistance from this chapter.

Westlock

Members participated in the civil defence program held at Immaculata Hospital. The chapter scholarship was awarded to J. Mountain, who recently entered a school of nursing. A fashion show was sponsored as a fund-raising project.

BRITISH COLUMBIA

Cranbrook

Miss J. Reid, physiotherapist for the local branch of the Canadian Arthritis and Rheumatism Society, was the guest speaker at a recent chapter meeting. She outlined the treatment available and conducted a tour of her department, demonstrating and explaining the many mechanical and electrical aids. Mrs. S. L. Hewer of the Canadian Red Cross Society, Vancouver branch, also visited the meeting briefly to discuss the steps in establishment of a loan cupboard.

A scrapbook of press clippings recording the activities of the chapter and district has been initiated. At a recent meeting, members listened with interest as two representatives of Alcoholics Anonymous discussed the problems related to this condition. Mrs. C. Kram was the delegate to the annual R.N.A.B.C. meeting.

Ladysmith

D. Hallan attended the annual provincial meeting held earlier this year as the official chapter delegate. A donation of money was forwarded to assist in the purchase of uniforms for needy Greek nurses.

At the nurses' annual tea which was held in mid-May, a special party was arranged for the pre-school children who attended with their mothers while the latter enjoyed a display showing the prevention and treatment of poliomyelitis. Mrs. J. Field, a councillor for the Vancouver Island District, was guest speaker at one of the chapter meetings.

Prince George

A panel of speakers, Mmes D. Parks, L. Houde and Miss E. Gildner discussed the highlights of the Public Health institute held earlier. Topics included the latest developments in the care of the handicapped child, the control of staphylococcic infections, tuberculosis nursing and rehabilitation, the effects

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of stress in modern society. Special guests at this meeting were public health students from Saskatchewan University presently doing field work in the area.

Quesnel

Chapter members have donated books for the library of the new G. R. Baker Memorial Hospital. A cheque was forwarded in response to the plea for uniforms for Greek Red Cross nurses.

A bake sale in May helped to provide the funds necessary for a bursary to be given to one member of the Future Nurses' Club who enters nursing. Plans are progressing for the annual meeting of the district in September.

South Fraser Chapter

O. Clancy, president, was the representative to the annual R.N.A.B.C. convention this spring while J. Keays attended the Biennial Convention in Winnipeg. A donation was allocated to the Greek Red Cross to assist with the work of this group.

Trail

Plans have been made to give Salk polio vaccine to preschool children and those in grades three to nine. Booster doses will also be available for those who were inoculated last year. Mrs. Morris and Mrs. Miller have been appointed to the committee responsible for administering the Alice Chesser Memorial Fund.

Vancouver

St. Paul's Hospital

Mrs. G. Collishaw represented the alumnae association at the annual R.N.A.B.C. meeting in Nanaimo earlier this year. The class of August 1947 held a reunion at the home of Mrs. (Korte) Russell with 18 members present. A coffee party and sale of home cooking was sponsored by the Dunbar-Fairview group. Proceeds were donated to the Bursary and Benevolent Funds. Dr. E. M. Stevenson was a guest speaker at one of the regular meetings and chose the "Nurse's Orientation into Psychosomatic Medicine" as his topic.

Vancouver Island

Comox

The history of fluoridation of water supplies, a description of the comparative studies carried out at Brantford, Ont. and a comment on the acceptance of this practice in

Canada and the U.S. formed the theme of a very timely address by Dr. G. F. Gemeroy at a recent chapter meeting.

At a subsequent meeting Sr. M. Louise, a past vice-president of the Ontario Hospital Association, chose as her subject "The Nurse's Ideal — The Ideal Nurse" and remarked on the changes in the spirit of nursing effected by changes in nursing education and administration. D. Henderson and M. Cutler attended the annual provincial meeting as official delegates. A donation was made to assist in building up the fund to help Greek Red Cross nurses.

MANITOBA

BRANDON

The annual tea sponsored by the Association of Graduate Nurses was held earlier this year in the residence of the General Hospital. Homecooking and candy tables were featured. The event proved most successful both socially and financially. Proceeds will be used for scholarships for graduate nurses wishing to pursue further study in nursing education.

General Hospital

Seven student nurses received their caps and were welcomed into the school of nursing, late in April. H. Conroy, M. Edwards, S. Fleming, J. MacDonald, P. McCunn, S. Steppler, and S. Watson repeated the Florence Nightingale Pledge led by their director of nursing, Miss M. E. Jackson.

NEW BRUNSWICK

MONCTON

H. Hayes, president of the chapter, was appointed to attend the biennial convention. At a recent meeting, Mrs. C. Colwell reported from the Nursing Education committee that Miss Gionet, Hotel Dieu, is taking postgraduate study in Montreal while D. Steeves, R. MacKenzie and C. Donovan attended a three-day institute at Halifax on "Aspects of Rehabilitation." R. MacKenzie has completed a ten-weeks course at Dalhousie University in Mental Hygiene in Public Health. Rededication services for nurses were held early in May. Preparations for publishing a cook book as a chapter project are well advanced. It has also been decided that a prize for obtaining the highest standing in the principles and practice of nursing will be donated to a nurse from each of the city hospitals.

S. MacLeod, supervisor of obstetrics at Moncton Hospital, and L. Smith, field supervisor for the Department of Health, were guest speakers at one of the spring meetings.

SAINT JOHN

The private duty section of the local chapter held a supper meeting in the Royal Hotel early this spring with an attendance of 26. M. Downing was the guest speaker and gave a most interesting description of her trip to Guatemala.

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General Hospital

The proceeds of a successful pantry sale are being used by the alumnae association to help furnish a room in the new residence.

P. Radcliff and J. Rawding have enrolled for postgraduate study in the Montreal Neurological Institute. M. K. O'Brien has undertaken a three year course of study in Nursing Science at Boston University. D. Pickett has joined the staff as assistant supervisor on Fourth floor. Miss Pickett, a recent graduate, obtained second place standing in the provincial examinations for registration. Other appointments to the staff have included M. McGarrity and B. Byron, 1st floor; C. Fife and E. Clark, 3rd floor; P. Tolan, 2nd Floor; A. M. McLaughlin, nursery; R. Cashal, O.R.

To assist the alumnae association with its project of publishing the history of the school of nursing, the Juniorettes presented the "Pulse Takers Jamboree" — an evening of plays, monologues, singing and dancing which was thoroughly enjoyed by all who attended.

NOVA SCOTIA

SYDNEY

City of Sydney Hospital

A review of the activities of this alumnae association demonstrates clearly the value of such an organization and the devotion and industry of its members. The main objective is service — to the hospital, to the student nurses, to alumnae members.

A private room in the new building has been furnished by the members of the association. A television set and other electrical appliances have been donated to the student residence. The living room and kitchen of the same building were renovated as another alumnae project. Funds have been donated at various times for student parties and dances, and Community Concert tickets supplied. A loan fund has been made available to any graduate of the hospital wishing to pursue further studies. Each year a banquet is given in honor of the graduating class and two prizes are donated to the two members of the class who perform outstanding work in dietetics. Sick graduates or students receive special attention in the form of greeting cards, flowers and visits.

Funds for these activities are raised through sales of homecooking, knitted goods, other articles of sewing and dolls. Parcelpost packages and bridge parties are an additional source of revenue.

ONTARIO

DISTRICT 1

LONDON

Victoria Hospital

A gift of $50,000 to be used in the foundation of a memorial to the late Miss Ione Holdsworth was recently received by the

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hospital. The contribution was a bequest in the will of the late Mr. Byron Lee Thurber, a Canadian who settled in South Africa. Miss Holdsworth, who had helped to care for Mr. Thurber during a sudden illness while he was visiting Canada, died in an automobile accident in 1941.

The alumnae association this year celebrates its 50th anniversary. It has been planned to postpone any large-scale activities in recognition of the occasion until 1958 when the school of nursing will celebrate its 75th anniversary.

Miss O. Branion retired early in 1955 after 29 years of devoted service to her hospital. She has the enviable record of never having lost one day's work through illness during that time. Miss Branion was the guest of honor at a surprise party given by over 200 nurses and associates who had served under her guidance. The medical staff of the hospital arranged a luncheon in her honor. On each occasion she was the recipient of beautiful gifts. Members of the Hospital Trust, the staff of Fifth Floor N, and the nursing staff also expressed their appreciation through presentation of gifts.

Miss V. Vance also retired after 34 years of service as a public health nurse. A reception was held at the service center of the hospital and a presentation was made by Dr. C. A. Harris.

D. C. Hall has been appointed to the faculty of nursing education at the University of Bangkok, Thailand. G. Erskine has accepted the position of assistant director of nursing service in her home school. E. McIlveen is pioneering in the teaching of public health to students in Teachers' College, Toronto. M. Drummond is attending the University of Toronto where she is enrolled in the advanced course in administration and supervision in public health nursing. N. Hicks is doing school nursing in Ottawa. G. Appleyard is on the staff of the Obstetric Hospital, Hamilton. Mrs. H. (English) Mason has returned to St. Petersburg, Fla. after completing special study at Columbia University. H. Sentesy is an air-hostess with T.C.A. and is presently stationed in Montreal. N. Shepanski has joined the staff of Ann Arbor University Hospital. G. Earnest and B. Jinx are on the staff of the King Edward VII Memorial Hospital, Bermuda.

The alumnae association celebrated its 50th anniversary in May with members of the 1956 graduating class present as guests of honor. The highlight of the evening was a pageant entitled "Remember When" presented by members of the alumnae under the direction of Mrs. G. McCulloch. Several charter members were also present as guests of honor: Mrs. M. Patterson; Miss L. Uren,

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first secretary-treasurer; Mrs. J. Atcheson; Mrs. E. M. Kidd; Mrs. G. Wilson, 1906 alumnae president. Ceramic figurines depicting uniforms worn by nurses over the last 70 years decorated the head table at the anniversary dinner. They were prepared by Mrs. J. Fisher. Banquet tables were centred with yellow and purple flowers carrying out the anniversary theme and the school colors. The anniversary cake was cut by Mrs. Wilson, and a cake symbolic of the three years of professional training was cut by Miss L. Blair, a member of this year's graduating class. Both cakes were baked by Mrs. A. Blair in honor of her daughter's graduation.

This was a most successful event and members are already anticipating the functions to come when the hospital celebrates its 75th birthday in 1958.

Miss Helen G. McArthur gave the address to the graduating class at their exercises. She stressed the unique opportunity offered nurses through the joy of accomplishment in the many fields of activity open to them. The impact of nursing on the international scene as a stabilizing force was also emphasized. Scholarships for postgraduate study, donated by the auxiliary, were awarded to Barbara G. Brown and Margaret A. Cochrane.

District 2

Woodstock

General Hospital

P. Smith, hospital administrator, addressed the alumnae association at a recent meeting, on "The Use of Drugs." Members of the graduating class of this year were guests of honor. Civil defence lectures are being given weekly for alumnae members and assistance with a tuberculosis survey has been undertaken as a major project. Provision of pyjamas for patients in the Children's Wing was another recent undertaking.

District 5

Toronto

The annual district meeting was held early in the year with election of the following officers: Ruth M. Watson, pres.; Mrs. R. Couse, J. Ives, vice-pres.; F. Howard, chairman, Chapter 1; Mrs. V. McPherson, chairman, Chapter 2. A highlight of the various reports was the fact that 63 student nurses have benefited by the Degree Course Bursary Fund.

Women's College Hospital

The Board of Governors has again offered a scholarship to a member of the graduating class who wishes to pursue postgraduate study in teaching or administration in schools of nursing. Although preference is given to an application from a member of the graduating group, any alumnae member in good standing may apply as well.

W. Adair is presently on the staff of the Glendale Community Hospital, California.

TORONTO

General Hospital

B. McCabe recently assumed the position of O.R. supervisor, Victoria Hospital, London. I. Moore, who has been matron of nursing at a leper colony near Hong Kong for several years, has returned to Canada on furlough. M. McMurtry is nursing in Hawaii. A. Coakwell has joined the Occupational Therapy Society of the city as a social service worker. L. Evans is studying in New York. D. Gildner, A. Maksinik and R. Gaw are working with T.C.A. M. Stinson is on the staff of the Outpatient department, Women's College Hospital. C. Campbell has joined the staff of the Eye Surgery Hospital. V. Day returned to her home school for a short time to take a refresher course.

G. McBroom has been appointed supervisor of the Private Patients' Pavilion with I. Ferguson as her assistant. E. Hawkett accepted a position as head nurse while A. Quinn and R. Rayfield are assistant head nurses. P. Osborne is doing private duty and A. (Sweetman) Hillmer is working in the Emergency Dept. S. (Robson) Veale has joined the staff of Ajax General Hospital. B. Chapman is a health nurse with the Canadian Kodak Co. M. (Kennedy) Briar is doing public health work in Vancouver. B. Rowland has joined the Charlottetown Public Health Dept. R. (Irvine) Graham is on the staff of Scarborough Township Board of Health and J. (Anderson) Williamson is with the East York Leaside H.U.

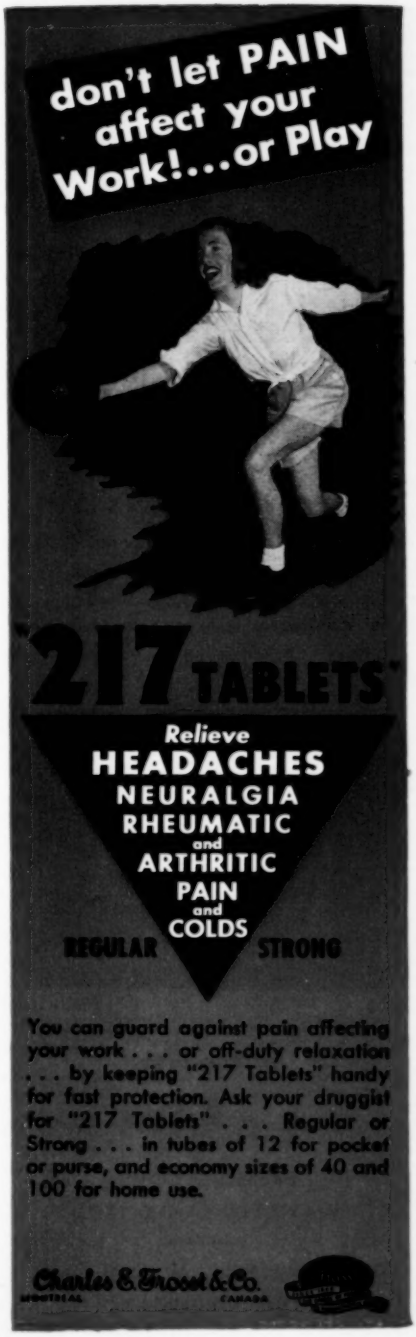
DISTRICT 8

OTTAWA

Civic Hospital

Plans are underway for a bazaar and tea to be held in the nurses' residence in November. Gift and knitting tables are to be featured as well as a sale of aprons made by the members. Donations for a post office sale are wanted — articles wrapped for mailing which will be sold unopened.

D. Grieves is on the staff of the General Hospital, Saint John, N.B. V. Holinshead has moved to the Outpatient Department of Toronto General Hospital. H. (Stephens) McLennan is presently taking a course in Intravenous Therapy and Dressing Technique in Vancouver. F. Alderwood is on the staff of Westminster Hospital, London. R. Miskelly is enrolled in the teaching and supervision course of the University of Toronto. D. McPhee is majoring in public health, Ottawa University. H. Kennedy is currently a member of Stormont, Dundas and Glengarry Health Unit, Cornwall. M. Langtry is on the staff of Peterborough Board of Health. Lieut. N/S J. Doerr has been posted to the staff of Kingston Military Hospital following completion of her public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health course, McGill University. V. MacRae is presently on the staff of the Royal Alexandra Hospital, Edmonton, while K. Pincombe is doing tuberculosis nursing at the Halifax Tuberculosis Hospital. Lieut. N/S M. B. Shaw has been posted to Whitehorse Military Hospital, Yukon Territory. S. Anderson has joined the staff of North Bay Civic Hospital. B. (Aikenhead) Carriere is clinical instructor of Victoria Hospital, Renfrew. G. Purpee has returned to the staff of her home hospital and E. Hodgins is engaged in private nursing in the city. L. Moke is with the Ottawa Public School Health Staff. I. Simister is nurse-in-charge with the V.O.N., Calgary. T. Pritchard has joined the staff of Temiskaming Health Unit. M. (Taylor) Berry is working on the Children's ward of North Lonsdale Hospital, Lancs., England. E. MacDougal is with the Galt Branch of the V.O.N. B. Loucks is nursing in the E. Crowe Memorial Hospital, Eriksdale, Man.

Lady Stanley Institute

The annual dinner of the alumnae association was held early in March. Guests were welcomed by Mrs. G. O. Skuce, president. Mrs. C. Port displayed many interesting items to be used for the Book of Remembrance. Following the business session, members in attendance listened to a reading by Miss M. Stewart, director of nurses of the Royal Ottawa Sanitorium in which she told of the love story of Florence Nightingale and the Reverend John Smithhurst.

Pembroke

This chapter has been enlarged to include the nurses of Deep River, Renfrew and Arnprior with a membership of 158 active nurses and 39 associates. Proceeds of a telephone bridge and raffle were used to help pay the expenses of a delegate to the Biennial Convention.

QUEBEC

District 3

Sherbrooke

The following members have been elected to executive positions in the English Chapter: C. Aitkenhead, chairman; O. Harvey, vice-chairman; A. Bertram, sec.; Mrs. D. Hudson, treas.; Committees: Educational, G. Norris; Private Nursing, Mrs. H. Morrison; Industrial Nursing, D. Symons; Public Health, Mrs. M. Watson; Institutional Nursing, L. Henshaw. Rep. to *The Canadian Nurse*, S. Carson.

Sherbrooke Hospital

As guest speaker at one of the staff meetings, Dr. R. Bayne discussed geriatric care from the point of view of nursing care involved, the necessity for adequate rehabilitation and the place of occupational therapy

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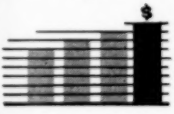

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DISTRICT 11

MONTREAL

General Hospital

Evelyn B. Moulton of the staff of Queen's University School of Nursing was a recent visitor. Margaret Keddie of the Royal Infirmary, Aberdeen, Scotland spent some time in observation in the hospital and school of nursing. She is sister-tutor in charge of the preliminary training school for Aberdeen general hospitals and is studying the methods of nursing education employed on this continent.

In mid-April a bridge party, under the sponsorship of the alumnae association, was held in Livingston Hall and proved most enjoyable and successful. Funds were in aid of the E. Frances Upton Memorial Fund. Miss Herman, the president, and her committee under the convenership of Miss Jensen deserved the credit for the success of the undertaking.

Plans for the combined reunion of past members of the resident medical staff and their wives and members of the alumnae association are progressing. A program of tours, teas, a fashion show, banquet and class reunions has been worked out and all graduates are most cordially invited to plan to attend.

The first issue of the alumnae news letter was distributed to members in April.

Royal Victoria Hospital

The graduating class of 1956 was honored at a dinner given by the alumnae association in the Ritz Carlton Hotel early in May. The toast to the guests of honor was proposed by Miss Mima Russell, class of 1896 and responded to by F. MacDowell. The guest speaker of the evening was Miss Edith MacDowell, Dean of the Faculty of Nursing, University of Western Ontario. The classes of 1931 and 1946 took this opportunity to enjoy a reunion of their members. Prize winners in the graduating class included S. Messenger, Mabel F. Hersey prize: J. Easson, Alexina Dussault prize; W. Cairns, Nellie Goodhue prize.

A large number of members and friends attended a tea during graduation week at which a portrait of the late Miss Fanny Munroe was unveiled. The portrait was presented to the hospital by Miss G. Purcell on behalf of the members of the alumnae association. It was unveiled by Mrs. Marjorie (Dobie) Munroe and accepted on behalf of the hospital by Mr. G. Blair Gordon, president of the Board of Governors. Painted by Mr. O. deLall, the portrait is an excellent likeness of Miss Munroe in her nurse's uniform.

The annual meeting of the alumnae association was held in the nurses' residence with election of a new slate of officers. Members of the executive include: Mrs. E. Butler, pres.; Miss H. Lamont, Miss D. Goodill, vice-pres.; A. Hathaway, rec. sec.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES

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(4) Regional Superintendent, 522 Dominion Public Building, Winnipeg 1, Manitoba.

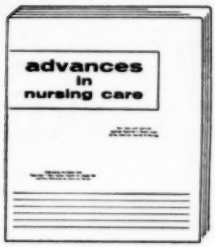
(5) Zone Supervisor of Nursing, Box 292, North Bay, Ontario.

(6) Zone Supervisor of Nursing, P.O. Box 3427, St. Roch Branch, Quebec, Que.

(7) Moose Factory Indian Hospital, Moose Factory, Ontario.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.



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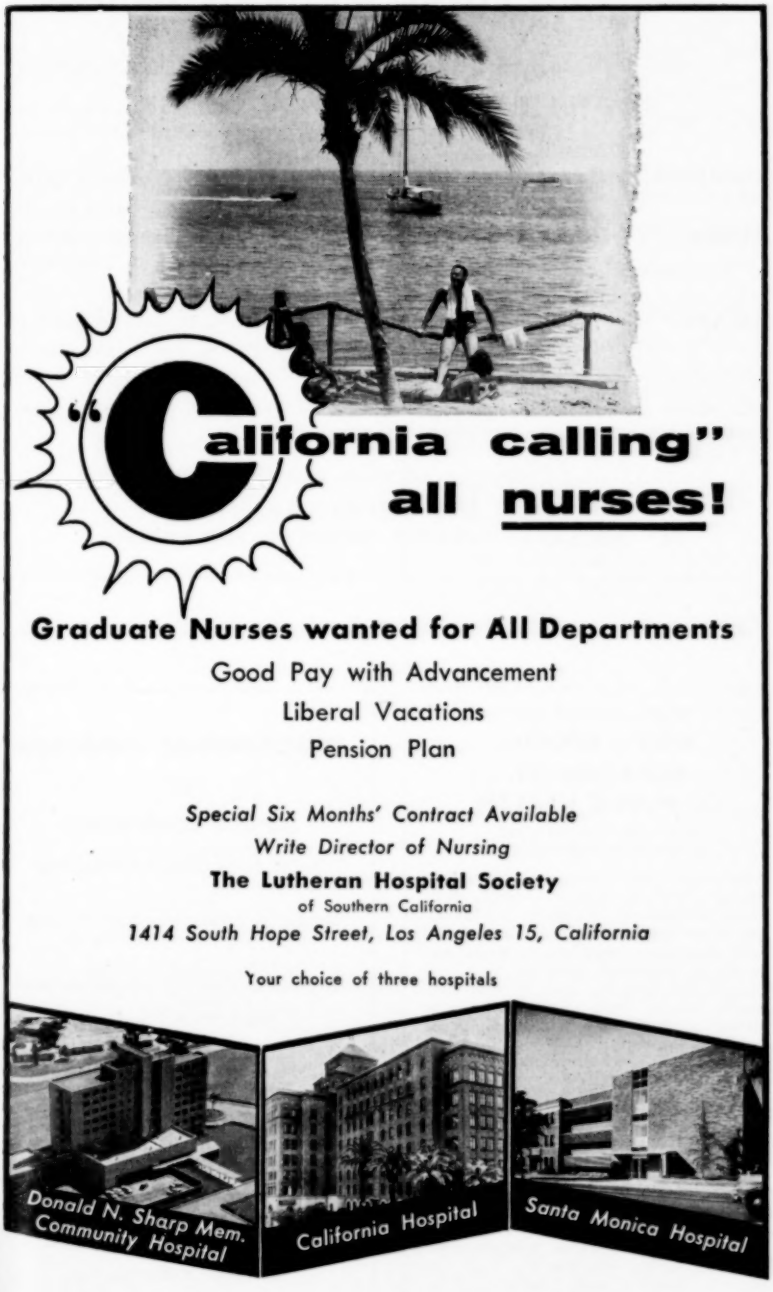
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Box 488, Halifax, Nova Scotia

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Asst. Director of Nursing for 450-bed hospital with school of nursing. Experienced, preferably with University Certificate of postgraduate training. Salary according to experience. 40-hr. wk. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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Nursing Arts Instructor for School of Nursing, with capacity 195 students, attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working toward degree. Located in "All American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Obstetrical Clinical Instructor for School of Nursing with capacity 195 students attached to expanding hospital of 571 beds. B.S. Degree in Nursing Education preferred or at least 3 yrs. experience & working towards degree. Located in "all American City" of 120,000 in North Eastern Ohio with educational, industrial, recreational & agricultural primary interests. Salary commensurate with qualifications. Write Director of Nursing, Aultman Hospital, Canton, Ohio.

Assistant Head Nurses & Staff Nurses for children's orthopedic hospital. Good personnel policies. Apply Director, Shriner's Hospital for Crippled Children, 1529 Cedar Ave., Montreal, Quebec.

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Registered Nurses for 82-bed accredited hospital. Gross salary $210-$230 per mo. 5½ day wk. with no split shifts. 30 days vacation with pay after 1 yr. service. Statutory holidays. Room in comfortable residence & laundry of uniforms provided at $8.00 to $12 per mo. Apply Supt. of Nurses, Union Hospital, Canora, Sask.

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General Duty Nurses. Salary: $230-270, $10 increment for experience. 40-hr. wk. 1½ days sick leave per mo. cumulative; 10 statutory holidays, (1) mo. vacation. Must be eligible for B.C. registration. Apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses (3) for 27-bed Community Hospital. Salary: $230 per mo. with annual increments of $5.00 per mo. 40-hr. wk. 28 days vacation after 1 yr. service. All statutory holidays paid. Room, board & laundry $40 per mo. Apply, giving full details, Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses for 430-bed hospital; 40-hr. wk. Statutory holidays. Salary: $235-268. Credit for past experience. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

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For further particulars apply:

NATIONAL DIRECTOR, NURSING SERVICES, CANADIAN RED CROSS SOCIETY,
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Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience to Matron, Terrace & District Hospital, Terrace, British Columbia.

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Graduate Nurses & Dietician (1) for new, very modern 88-bed hospital in a pleasant progressive town. Nurses salary: $200 per mo. Annual increase $10 per mo. for 3 yrs. 2-wk. shift rotation, bonus for night shifts. 1 hr. drive to Toronto & several resorts. Local swimming pool, bowling alleys, skating, theatres etc. Apply Director of Nurses, Dufferin Area Hospital, Orangeville, Ont.

Graduate Nurses for duty on Obstetrical, Medical & Surgical Wards. Personnel policies as recommended by the Assoc. of Nurses of the Prov. of Quebec. Please apply Director of Nursing, Queen Elizabeth Hospital of Montreal, 2100 Marlowe Ave., Montreal 28, Que.

Graduate Nurse (Bilingual) with psychiatric experience preferred, for private French family consisting of 2 adults & 5 children, 3 in school & 2 pre school age. Duties: Nurse companion with preventive care of the two younger ones, able to drive a car & willing to accompany any member of the family travelling especially during vacations. Necessary qualifications: Good character & ability to get along well with children essential. Please send references & salary expected. For further information communicate either by letter to Mr. Pierre Joron, 153 Price West, Chicoutimi, Que. or telephone LI 3-3487.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses (immediately) for operating room. Apply Director of Nursing, Civic Hospital, Ottawa 3, Ont.

Staff Nurses for 600-bed General & Tuberculosis Hospitals with student programs. In central valley, city of 108,000. State & Junior Colleges afford opportunity for advanced education. Salary $300 with 4 annual increases to $341. Full maintenance $45 per mo. Liberal personnel policies. Apply Assoc. Director of Nursing Service, County General Hospital, Fresno, California.

Staff Nurses for 500-bed General Hospital. Beginning salary: $300 per mo. with advancement to $335 for those eligible for registration in the state of Michigan. Additional differential $1.50 per afternoon or night. 40-hr. wk. Hospital & school of nursing fully approved. Apply Director of Nursing, The Grace Hospital, 4160 John R. St., Detroit 1, Michigan.

Nurses — Vacancies in all depts. in new hospital, located in same city with the large Warren Air Force Base. Come to "Wonderful Wyoming" to enjoy hunting, fishing, beautiful mountain trips to the Tetons, Yellowstone National Park & Rocky Mts. Salary commensurate with background, minimum $265-$300 per mo. 40-hr. wk. Apply Director of Nursing, De Paul Hospital, Cheyenne, Wyoming.

Operating Room Nurses. Good salary with credit given for experience or P.G. courses. 40-hr. wk. Liberal personnel policies. Apply Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.

DIRECTOR OF NURSING

350-BED GENERAL HOSPITAL 200 NURSING STUDENTS

Applications are invited for the position of Director of Nursing & Principal of School of Nursing. Good salary & personnel policies. Please furnish particulars of qualifications, experience & age.

For further information write to:

GENERAL SUPERINTENDENT, CITY HOSPITAL, SASKATOON, SASKATCHEWAN.

Operating Room Nurse, postgraduate training not essential. All graduate staff. A.N.P.Q. salary scale in effect. 8-hr. day, 5½ day wk. Apply Director of Nursing, Montreal Children's Hospital, Montreal, Que.

Operating Room Nurses, immediate appointments, for 511-bed newly enlarged and finely equipped hospital; 10 operating rooms now completed. Northeastern Ohio stable "All-American City" of 120,000. In centre of area of recreational, industrial and educational friendly activities; living cost reasonable. Within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburg, Pa. Friendly and considerate working associates and conditions. Progressively advanced personnel policies. Starting salary: $240 per mo. with 4 merit increases. Paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio, by letter or collect telephone 4-5673.

Surgical Nurses urgently needed by July for leading modern hospital. Salary: $275 plus benefits to $325. Fee paid by employer. Excellent location with many recreational facilities. **R.N.'s to assist in doctor's offices & clinics. Lab. tech., serology background,** salary open. Apply Medical Placement Bureau, 1115 S. W. Yamhill, Portland, Oregon.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Maintenance & salary as for general staff nurses. Opportunity for permanent employment if desired. Spring & Fall Classes. Further information on request.

Supervisor (1), Public Health Staff Nurses (2) for generalized program in city of 43,000. Blue Cross & P.S.I. employer shared. Transferrable accumulative sick leave & pension plans. Workmen's Compensation. Group ins. available. Transportation provided or allowance — 10¢ first 2,000 mi., 8¢ per mi. thereafter. 5-day wk. 1 mo. vacation with extra time at Christmas. Salary scales: (1) Supervisors, $3,600-$4,400 with annual increment of $200. (2) Field Nurses, $3,000 for inexperienced nurses to start with annual increments of $150. All starting salaries dependent on experience. For further information please write supplying details of training & experience to Medical Officer of Health, City Hall, Peterborough, Ont.

Public Health Nurse Grade 1. British Columbia Civil Service, Dept. of Health & Welfare. Starting Salary $255, $260, $266 per mo., depending on experience, rising to $298. per mo. Promotional opportunities available. Qualifications: Candidate must be eligible for registration in British Columbia & have completed a University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of the Province.) Cars are provided. 5-day wk. in most districts. Uniform allowance. Candidates must be British subjects; preference is given to ex-service women. Application forms obtainable from all Government Agencies, the Civil Service Commission, 544 Michigan St., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Civil Service Commission, Victoria. Further information may be obtained from the Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C.

GENERAL STAFF NURSES

For 526-bed General Hospital. Opportunity for advancement. Rotating or permanent evening & night assignments. 40-hr. wk., 6-hr. evening duty. Salary: $260-$300 with increase after 6 mo., 1 yr. & on merit thereafter. Evening & night bonus. Tuition assistance for university & college courses. 2 wk. vacation after 1 yr. service, 3 wk. after 2 yrs. Terminal vacation. 5-10 days sick leave after 1 yr. Uniforms laundered. Temporary housing in hospital residence at a nominal fee. Convenient transportation.

Apply DIRECTOR OF NURSING SERVICE,
SAINT LUKE'S HOSPITAL, 11311 SHAKER BLVD., CLEVELAND 4, OHIO

PEDIATRIC INSTRUCTOR

Responsible for classroom and clinical instruction in pediatric nursing & co-ordinating maternal & child care program in school where organizational set-up permits stressing of patient-centred care and student-centred learning activities.

For further information apply:

DIRECTOR, SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.

Public Health Nurse (Qualified) for Haldimand County, School Health Service. University certificate in Public Health Nursing required. State qualifications, experience & salary expected. Apply E. B. McPherson, Lowbanks, Ont., telephone, Wainfleet 104 R-3.

Public Health Nurses. Duties to commence between June & Sept. 1956. Salary: $2,796-$3 396. 5-day wk. 1 mo. vacation. Pension plan. Apply Dr. W. H. Hill, M.O.H., Dept. of Health, Calgary, Alta.

Public Health Nurses for generalized program in rural-suburban Health Unit near Toronto. Minimum salary: $3,000. Pension plan. For full details apply Supervisor, Peel County Health Unit, Court House, Brampton, Ont.

Public Health Nurses (qualified) for generalized program. Salary $2,700 to $3,200 depending on experience. Annual increment $100. 5-day wk. Pension plan. Blue Cross & P.S.I. available. Car provided or car allowance. Apply Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ont.

Public Health Nurses for Wentworth County Health Unit. Generalized program. Minimum salary without experience $2,800. 5-day wk. Pension plan. Blue Cross. Liberal car allowance. Apply stating qualifications, experience & salary expected to A. F. Stewart, County Clerk, National Revenue Bldg., Hamilton, Ont.

Public Health Nurses for generalized program, bedside nursing included. Rural area. Blue Cross & group ins. available. Good transportation policy. 4-wk. vacation after 1 yr., statutory holidays. Apply Dr. J. I. Jeffs, Lennox & Addington County Health Unit, Napanee, Ont.

Public Health Nurse (1) for generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group ins. & transportation arrangements. Apply Dr. R. M. King. York County Health Unit, Newmarket, Ont.

Public Health Nurses (qualified.) Salary: $3,100 depending on dist. served, less if in the Timmins area. Annual increment $150 per annum for 4 yrs. Additional allowance for experience & if French-speaking. 5-day wk. 4-wk. vacation, 18 days sick leave annually (cumulative.) Car is provided. Half cost of uniform is allowed & half of Blue Cross. Workmen's Compensation. Good working conditions. Apply Sec.-Treas., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ont.

THE PROVINCE OF MANITOBA

requires a

SUPERINTENDENT OF NURSES

for the School for Mentally Defective Persons at Portage La Prairie, Manitoba. Applicants should be qualified in Psychiatric Nursing, registered Nurse preferred.

Experience or postgraduate study in administration would be an asset.

The above position offers full Civil Service benefits, Liberal sick leave, four weeks' vacation annually with pay and pension privileges.

Apply stating qualifications, experience and salary expected to:

MANITOBA CIVIL SERVICE COMMISSION

247 Legislative Building, Winnipeg, Manitoba.

EMPLOYMENT OPPORTUNITIES FOR GRADUATE NURSES

Due to the opening of a new wing in a well-equipped, new 125-bed hospital in Suburban Toronto. Residence accommodation optional.

SALARY RANGES

GENERAL DUTY	$205 - $275 monthly
HEAD NURSES	$225 - $295 monthly
SUPERVISORS	$240 - $310 monthly

Enquire:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL
200 CHURCH ST., WESTON, TORONTO, ONTARIO

Public Health Nurse for an expanding program in a growing suburban municipality. Minimum starting salary: $3,200 with regular merit rating increases & car allowance. 20 days vacation after 1 yr. service. Address inquiries to the Personnel Director, Township of Etobicoke, 4941A Dundas St. W., Toronto 18, Ont.

Nurse Technician (Immediately) preferably trained for intravenous therapy, transfusions etc. Apply Asst. Supt., Civic Hospital, Ottawa, Ontario.

General Duty Nurses (3), O.R. Scrub Nurse for new 143-adult bed plus 30-bassinette hospital. Good personnel policies. Starting salary: $215 per mo. Apply Director of Nurses, Plummer Memorial Hosp., Sault Ste. Marie, Ontario.

Operating Room Supervisor, Operating Room Nurse, General Duty Nurses for 100-bed hospital in friendly resort town. Excellent personnel policies. For information apply Director of Nursing, Norfolk General Hospital, Simcoe, Ontario.

Superintendent (Sept. 1, 1956 or before) for modern 50-bed Community Hospital, 50 mi. from Ottawa. Full maintenance. 1 mo. vacation with pay after 1 yr. service. 7 statutory holidays. Apply stating qualifications & references to Sec. to the Board, Pontiac Community Hospital, Shawville, Que.

Science Instructor (1), Nursing Arts Instructor (1) for August. 10-15 students per class. Salary: $230 per mo. Apply Director of Nursing, General Hospital, Brandon, Manitoba.

Registered Nurse, ambitious to broaden knowledge in clinical laboratory, hematology, serology, chemistry & x-rays. Willing to complete American Med. Technician registration. Earning 3-wk. vacation, full expense convention trip. Live-in maintenance, uniforms laundered. Use of car, plus $4,200 cash. Easily bettering $6,600 annually or $3.00 per hr. worked. (Tuition free.) Beautiful model small hospital & clinic. 18 mo. to 3 yr. contract. Apply Dr. Keyes, Keyes Dearborn Clinic & Diagnostic Hosp., 4840 Maple, Dearborn, Michigan.

Graduate Nurses for Psychiatric & General Duty at Wayne County Gen. Hospital & Infirmary, Eloise, Mich., located 17 mi. from downtown Detroit. Salary range: $4,360-$4,840, 40-hr. wk. Some 48-hr. positions open at $5,668-$6,292. Liberal vacation & sick leave. Candidates must be graduates of accredited Canadian nursing schools. Visa required. For information apply Wayne County Civil Service Commission, 628 City-County Bldg., Detroit 26, Michigan.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty-four hour week. Salary $220 to $260 gross per month. Differential for evening and night duty, Residence Accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

CLINICAL INSTRUCTOR IN PEDIATRIC NURSING

Position vacant in July, 1956 in modern well equipped school. Present enrollment 54 students. Gross minimum salary: $3,302 per yr. 5-day week. 28-days vacation after 1 yr. 9 statutory holidays.

Apply:

PERSONNEL DIRECTOR, GENERAL HOSPITAL, SARNIA, ONTARIO

CITY OF WINNIPEG MUNICIPAL HOSPITALS

has openings for

REGISTERED NURSES

40-hour week; Statutory holidays; Liberal sick time; Pension plan; Holiday allowance.

Accommodation available in Nurses' residence.

Uniforms laundered free

Salary: min. $215; max. $248
(increment every 6 mo.)

EVENING DUTY ADDITIONAL $10

Apply

SUPERINTENDENT OF NURSES
WINNIPEG MUNICIPAL HOSPITALS
MORLEY AVE., EAST,
WINNIPEG 13, MANITOBA.

CITY OF WINNIPEG MUNICIPAL HOSPITALS

has openings for

PRACTICAL NURSES

40-hour week; Statutory holidays; Liberal sick time; Pension plan; Holiday allowance.

Accommodation available in Nurses' residence.

Uniforms laundered free

Salary: min. $169; max. $188

Apply

SUPERINTENDENT OF NURSES
WINNIPEG MUNICIPAL HOSPITALS
MORLEY AVE., EAST,
WINNIPEG 13, MANITOBA.

OPERATING ROOM SUPERVISOR

EXPERIENCED POSTGRADUATE PREFERRED

This is a well-equipped department in a new modern hospital located in south western Ontario.

Apply stating age, experience & salary desired to Box A,

The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Que.

REGISTERED NURSES
$2,610-$3,360

CERTIFIED NURSING ASSISTANTS
$2,040-$2,220

SUNNYBROOK HOSPITAL
TORONTO

WESTMINSTER HOSPITAL
LONDON

Application forms, available at your nearest Civil Service Commission Office, National Employment Service & Post Offices, should be forwarded to the

CIVIL SERVICE COMMISSION,
25 ST. CLAIR AVE. E., TORONTO 7, ONTARIO

General Duty Nurses for all departments. Gross salary: **$210** per mo. if registered in Ontario **$200** per mo. until registration has been established. **$20** per mo. bonus for **evening or night duty;** annual increment of **$10 per mo.** for 3 yrs. **44-hr. wk., 8 statutory holidays,** 21 days vacation & 14 days leave for illness with pay after 1 yr. of employment. Apply: Director of Nursing. General Hospital, Oshawa, Ont.

General Duty Nurses for modern 42-bed hospital. Excellent equipment & facilities. Starting salary: $225 per mo. Annual increments. Good personnel policies. Apply Supt. of Nurses, General Hospital, Sioux Lookout, Ont.

General Duty Nurses for 650-bed teaching hospital in central California. Salary: **$288-$337** per mo. 40-hr. wk. Liberal vacation, holiday & sick leave plan. Apply Personnel Office, 510 E. Market St., Stockton, California.

REGISTERED NURSES
NURSING ASSISTANTS
ORDERLIES

Required for all Departments in New 150-bed General Hospital

Excellent Salary & Personnel Policies

Hospital scheduled to open August 1st, 1956

Apply

DIRECTOR OF NURSING,
QUEENSWAY
GENERAL HOSPITAL
TORONTO 14, ONTARIO

Graduate Nurses (2) for general duty. Salary: $250 per mo. 8-hr. day, 5-day wk. Room & Board $45 per mo. Transportation paid one way after 6-mo. service. Apply Matron, Queen Charlotte Islands Hospital, The United Church of Canada, Queen Charlotte City, B.C.

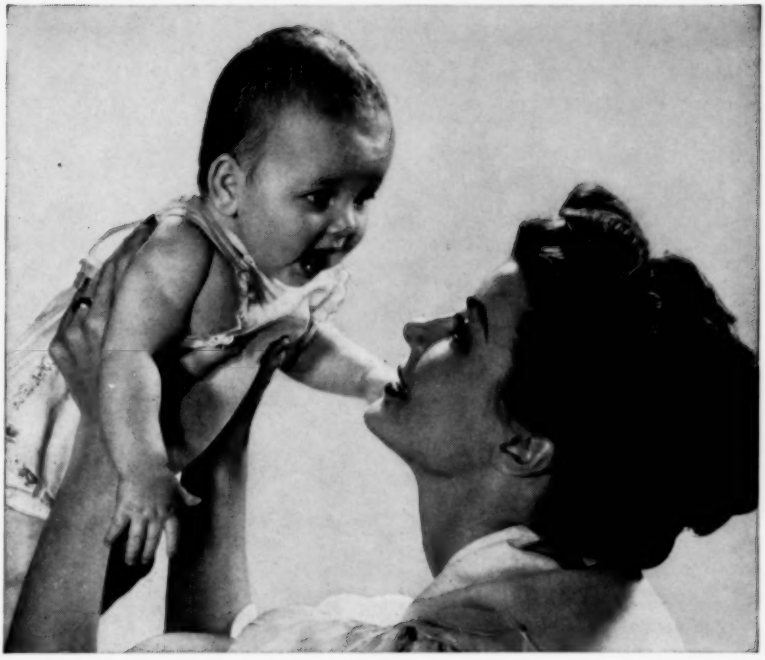
General Duty Nurses for 40-bed active hospital. Salary: $250 per mo. less $45 full maintenance in comfortable nurses' home adjacent to hospital. 42-hr. wk., rotating shifts, 28 days annual vacation plus 10 statutory holidays, cumulative sick leave. This is an active friendly community located on the scenic Hope-Princeton highway with easy access to the beautiful Okanagan or westward to Vancouver. Apply Director of Nursing, General Hospital, Princeton, B.C.

Public Health Nurses (Qualified) for generalized public health nursing service. Salary range: $3,186 - $3,618. Starting salary based on experience. Annual increments, 5-day wk., vacation, sick pay & pension plan benefits. Apply Personnel Dept., Room 320, City Hall, Toronto, Ont.

Pediatric Supervisor (Experienced with postgraduate study) for supervision of Children's Ward & Nursery in 100-bed hospital. Apply Director of Nurses, Royal Alexandra Hospital, Edmonton, Alberta.

Geriatric Nursing Assistant with practical ideas. Should be a graduate, not necessarily recent. Small privately endowed home in Maritimes with pleasant atmosphere. Apply Box B, The Canadian Nurse Journal, 1522 Sherbrooke St., W., Montreal 25, Que.

Interested in an 8-week Tour of Europe? Miss Viola Vandervoort, Surgical Instructor of Oshawa General Hospital, Oshawa, Ont. who is planning an 8-wk. vacation after the ICN Congress in 1957 in an English car she plans to purchase — it will be delivered either to London or Rome. — would like someone who would be interested in accompanying her & sharing expenses.



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